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ABSTRACT

**WHOLE PATIENT CARE: AWARENESS AND ATTITUDE
OF BABCOCK UNIVERSITY TEACHING HOSPITAL
HEALTH CAREGIVERS**

by

Victoria T. Aja

Adviser: Johnny Ramirez-Johnson

ABSTRACT OF GRADUATE STUDENT RESEARCH

Project Document

Andrews University

Seventh-day Adventist Theological Seminary

Title: WHOLE PATIENT CARE: AWARENESS AND ATTITUDE OF BABCOCK UNIVERSITY TEACHING HOSPITAL HEALTH CAREGIVERS

Name of researcher: Victoria T. Aja

Name and degree of faculty adviser: Johnny Ramirez-Johnson, Ed.D

Date completed: April 2014

Statement of the Problem

This study seeks to understand Babcock University Teaching Hospital (BUTH) health caregivers' awareness of and attitude to whole patient care for the purpose of developing whole patient care at BUTH. I have been tasked to help develop and establish whole person care at BUTH. Babcock University Teaching Hospital is still at a developmental stage. It has not established an institutional definition of whole patient care, nor has it established an institutional office for the promotion and administration of whole patient care or hired a full-time chaplain.

Method

This study adopted a quantitative (survey) and qualitative (Focus Group

Discussion) mixed methods research design. A two-day workshop, comprised of lectures and Focus Group Discussion (FGD) was conducted at BUTH to create awareness on the importance of whole patient care for the purpose of developing and contextualizing whole patient care in the BUTH setting. Sixty-six staff participated in the study. Fifty-four (54) of the 66 responded accurately to the quantitative survey, amounting to an 81.81% participation rate, while all the 66 (100%) participated in the FGD.

Prior to the workshop, a questionnaire was developed and administered to determine participants' awareness of and attitude towards whole patient care and at the end of the lectures and FGD, the same questionnaire used at the beginning of the workshop was administered to determine the influence of the lectures and FGD on participants' awareness of and attitude to whole patient care.

After the lectures, FGD was conducted to determine how to contextualize whole patient care in the BUTH setting. Finally, participants were asked to evaluate the intervention, i.e. the lectures and FGD, to determine its relevance to the workshop.

Results

The overall outcome of the study indicated an increase in participants' awareness of and attitude to whole patient care. The mean score after the workshop was higher than the mean before the workshop ($P < 0.05$), an indication that participants understood the importance of whole patient care and wished for the development of whole patient care at BUTH. The qualitative data generated a number of themes supporting the overall outcome. Emerging from the themes is the BUTH philosophy and definition of whole patient care as supposed by the participants.

Conclusions

The post-workshop survey showed that the workshop elicited a change in the opinion of many participants who, at the beginning of the workshop, felt that BUTH had no further need for change in its philosophy of care and approaches. Participants embraced whole patient care in all its facets and wished for its development at BUTH. However, participants felt that the success and sustainability of whole patient care at BUTH is reliant upon staff welfare/motivation and leadership attitudes. A dialogue between BUTH management and staff on staff welfare/motivation and its influence may facilitate quality whole patient care at BUTH.

From this, it can be seen that whole patient care is vitally important. The evidence is based on the interrelatedness among the physical, spiritual, social, emotional aspects of human life and the positive effects of these aspects of human life on health as presented in Chapter 3. Moreover, as discussed in Chapter 2, whole patient care is fundamentally rooted in the Bible. It was evident in the healing miracles Jesus performed and in E. G. White's writings.

Andrews University
Seventh-day Adventist Theological Seminary

WHOLE PATIENT CARE: AWARENESS AND ATTITUDE
OF BABCOCK UNIVERSITY TEACHING HOSPITAL
HEALTH CAREGIVERS

A Project Document
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry

by
Victoria T. Aja

April 2014

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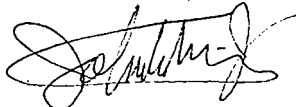
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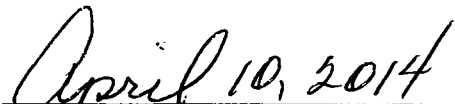
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LIST OF ABBREVIATIONS

ASWA	Adventist Seminary of West Africa
BU	Babcock University
BUMC	Babcock University Medical Center
BUTH	Babcock University Teaching Hospital
KJV	King James Version
NIV	New International Version
NLT	New Living Translation
SDA	Seventh-day Adventist Church
WAUM	West African Union Mission

ACKNOWLEDGMENTS

I give glory to God for direction, guidance, provision, and life. It is the Lord's doing and it is marvelous in my eyes.

I am grateful to my adviser, Johnny Ramirez-Johnson Ed.D; my second reader, Siroj Sorrajjakool, Ph.D.; and my third reader, Mario Ceballos, DMin. My sincere appreciation also goes to the research coach, David Penno, Ph.D. Thank you all for your contributions to the success of this work; I respect your expertise.

I appreciate my husband, Godwin Aja, DrPH, and my children, Ezinne and Joyce, for their encouragement, prayers, and support in various ways beyond measure and the same appreciation goes to my parents and siblings. My sincere appreciation goes to the following people and institutions for their immeasurable contributions to my academic success and some other aspects of my life: Professors Siroj Sorrajjakool, Johnny Ramirez- Johnson, David Taylor, Carla Gober Park, Mark Carr, Jim Greek, Vaughan Grant, Najeeb Nakhle, Robert Benjamin, Donna Herrick, all my Clinical Ministry and Doctor of Ministry teachers and research coach, the entire Staff and Faculty of Loma Linda University School of Religion and the Loma Linda University Medical Center Chaplaincy Services from 2005 to the present, the entire Staff and Faculty of Andrews University Theological Seminary from 2009 to the present, the entire Staff and Management of BUTH, and of course, my employer, Babcock University. Your contribution to my success is immeasurable. To God be the glory!

CHAPTER 1

INTRODUCTION

I have been tasked to help develop and establish whole patient care at Babcock University Teaching Hospital (BUTH). This task, coupled with the value the Seventh-day Adventist (SDA) Church places on whole person care (Dolson & Spangler, 1975), and the association between physical, spiritual, and emotional health (Rice, 2004) prompted me to investigate BUTH health caregivers' awareness of and attitude to whole patient care.

By 1975, the medical world had earnestly begun to recognize the fact that treatment is incomplete unless it addresses the whole human being (Dolson & Spangler, 1975). According to Rice (2004), illness affects every aspect of man; thus, when ill health is addressed, other aspects of man must also be addressed. "Every physical problem has emotional, spiritual, or social ramifications, and every emotional, spiritual, or social problem has physical impact" (Rice, 2004, p. 17). Similarly, Behrens (as cited in Alexander, 2008) affirmed that whole person care extends beyond treating the presenting illness; it involves taking into cognizance the physical, intellectual, emotional, social, and spiritual aspects of the sick individual. It is when all the aspects are attended to that it could be said that whole person care has taken place.

Personal History

About five decades ago, I was born to Pastor Gabriel and Mrs. Rebecca Solademi.

My parents are God fearing and they brought up their children in like manner. I had five siblings until 2009, when our oldest brother died at the age of 58; what a great loss to the family. I am the youngest of all. I really value my parents and siblings and I could say that we are a closely knit family.

On November 29, 1992, I got married to Godwin Aja and the marriage has been blessed with two lovely girls. I am very grateful to God for where my marriage stands today. It is smoother than when we first began.

My being in the chaplaincy ministry is God's will for me—a call orchestrated by God himself. I love teaching and this was apparent from a very young age. After I completed my secondary school education, I applied to the National College of Education and based on my performance, I was assured of admission. While the admission was taking place, I applied to the Adventist Seminary of West Africa (ASWA, now Babcock University) in Nigeria to study Theology. Though a pastor's daughter, I never really thought of going into my father's profession and my father never at any time dictated directly or indirectly the profession I should choose. Today, when I look back, I see the hand of God in the choice I made.

In 1990, I was awarded a Bachelor of Arts degree in Theology (being the first female SDA from Nigeria to earn such a degree). Between 1991 and 1994, God used me tremendously as an assistant chaplain for the Ile-Ife Seventh-day Adventist Hospital in Nigeria and as a Bible instructor for the Voice of Prophecy Correspondence School in Ibadan, Nigeria. For the first time in the history of the Bible school, we visited students in their homes and organized and conducted graduation ceremonies for students in many districts of the West Nigeria Conference of the Seventh-day Adventist Church. Meeting

with students face-to-face provided the opportunity for them to ask further questions.

In 1994, my service was transferred to ASWA where I worked at the Registry and Academic Dean's office as an administrative officer until December 1997. In 1998, I took a leave of absence to take care of my two young children and I did this while I studied. In 2000, I earned a Masters degree in Educational Management (MEd) and went back to work. In 2000, Babcock University established a chaplaincy unit and I became the first female chaplain and served until 2004. During that period, I introduced several activities/programs such as the use of prayer boxes in residence halls, visiting students in the residence halls, and *Read along* and *Dig deep* (programs that provided tracts and literature to students who were interested).

In 2004, my two daughters and I relocated to California, USA to support my husband who was working on his Doctorate in Public Health at Loma Linda University. In 2008, my husband finished his doctorate degree and in the same year I got a master's degree in Clinical Ministry from the same University. Clinical ministry has widened my theological perspective and has positively impacted the way I minister to people. In 2008, my family and I returned to Babcock University where I continue to serve as a chaplain and as adjunct lecturer in the Department of Religious Studies. My goal upon returning was to improve the chaplaincy ministry and to promote whole person care at the Babcock University Teaching Hospital. So far, tremendous progress has been made.

Desiring to improve my ministry and much more by the divine will of God, I enrolled in the Doctor of Ministry program at Andrews University, Michigan in 2009 and at the same time continued with my training in Clinical Pastoral Education (CPE) at Loma Linda University Medical Center. In 2012, by the grace of God, I completed the

Four Units of CPE. The current project I am working on is the last requirement for the Doctor of Ministry degree.

Being a woman in ministry in my country has had peculiar challenges. Nevertheless, I have no regrets whatsoever for going into ministry. I believe the Lord who has called me and channeled my path to the present will continue to lead me and use me to His glory.

On my arrival after further studies and having specialized in the healthcare chaplaincy ministry, I shared my vision regarding the hospital chaplaincy ministry and whole patient care with the administrator of Babcock University Medical Center (now Babcock University Teaching Hospital) and with the director of the Babcock University Chaplaincy Unit. To me, hospital chaplaincy ministry is much more than counseling and praying for and with patients and staff. It also needs more than a part-time chaplain. Ironically, in January 2011, I was assigned as part-time BUMC Chaplain. Sharing my vision with the BUMC Administrator continued and this led to the birth of this project. It should be noted that this project began when the hospital was called BUMC and while the project was still going on, the hospital name was changed to BUTH.

History of Babcock University and Babcock University Teaching Hospital

Babcock University

Based on the fact that BUTH is an arm of Babcock University (BU), it is necessary to discuss BU history briefly before that of BUTH. Babcock University is situated in Ilishan-Remo, Ogun State, Nigeria. It is located between the two major cities of Ibadan and Lagos. Babcock University was established on September 17, 1959 by the

Seventh-day Adventists (SDA) as one of their world-wide network of colleges and universities (Babcock University 2008-2009 Bulletin). According to Babalola (2002), the hardship of long distance travel to Ghana in the early 20th century to obtain a higher degree prompted the Seventh-day Adventist Church leaders in Nigeria to ask then West African Union Mission of Seventh-day Adventists to establish an institution of higher learning in Nigeria. The leaders of the West African Union Mission (WAUM) of SDA accepted the proposal, but felt that the proposed institution had to serve all countries in the WAUM. As a result, WAUM leaders pointed out that the proposed institution had to be in a location that was central for the countries in the WAUM. Ghana and Western Nigeria seemed the most central (other countries that made up WAUM included Gambia, Sierra Leone, Liberia, Ivory Coast, British Togoland, Upper Volta (now Burkina Faso), Dahomey (now Benin), and British Cameroon). After much deliberation, an agreement was reached and the leaders of the Ghana and Nigeria Missions were asked to look for a suitable site. The “lot” fell on the Western Nigeria Mission. In mid- August 1957, Gordon M. Ellstrom, President of the Western Nigeria Mission and Roger W. Coon, Director of the Voice of Prophecy Bible Correspondence School of West Africa, both located at Ibadan, went in search of a suitable place to locate the proposed institution of higher learning. After much searching, they settled for Ilishan-Remo, Ogun State.

The Ilishan property met the minimal criteria stipulated by WAUM leaders: adequate acreage for major campus development, including sufficient fertile space for farming; an adequate water supply; readily available commercially generated electricity; and close proximity to major cities. Finally, on June 4, 1958, the WAUM committee voted to lease 370 acres of land at Ilishan for 99 years and on September 17, 1959,

Adventist College of West Africa (ACWA) was established and opened its doors to the first set of seven students (Babalola, 2002). In 1975, the name of the college was changed to Adventist Seminary of West Africa (ASWA) in response to the Nigerian Government's attempt to take over the College. In 1999, ASWA got a charter to operate as a private University; thus, BU was born (Babcock University Information Brochure, 1999).

Today (as of the 2012/2013 Academic Session), the BU student population is about 8000. The University offers 35 undergraduate and 16 postgraduate courses in the following schools: Education and Humanities, Basic and Applied Sciences, Business, Agricultural Science and Industrial Technology, Computer Science and Engineering, College of Health and Medical Sciences, Nursing, Public and Allied Health, and Law and Security Studies (BU Convocation Bulletin, 2012).

Babcock University Teaching Hospital

The history presented below is based largely on the work of Dr. John Sotunsa who, for the first time, penned a detailed history of Babcock University Teaching Hospital (BUTH) from inception to 2006. Dr. John Sotunsa joined BUTH in 2002. He served as acting Medical Director between 2005 and 2011 and he is currently the Director of Clinical Services.

According to Sotunsa (2006), the Seventh-day Adventist Church believes that medical ministry is the right hand of the gospel and so, from its inception, Adventist College of West Africa provided healthcare services to its students and staff through what can be referred to as a "college nurse system of care." Mrs. Sufficool was appointed in 1960 as the first college nurse. She treated and cared for the minor ailments of students

and staff. Severe cases were transferred to Sagamu General Hospital or the Ile-Ife Adventist Hospital.

At some point, the indigenous Ilishan community people began to ask the college nurse to provide medical treatment for them. Chief J. S. K. Osibodu, one of the community leaders of Ilishan town, played a prominent pioneering role in the establishment of the Adventist Medical Center in the community. He wrote several letters to the Adventist leaders both in Nigeria and overseas advocating a medical center in Ilishan town. Chief Osibodu's quest for a medical center in the community began in 1964, but it was not until 1972 that his request was fully granted.

Meanwhile, the college system of care continued. In 1963, Mrs. Canthrel took over the position and worked until 1968. Mrs. V. Awoniyi became the third college nurse and served from 1968 to 1973. One early morning, a lady from Ilishan community came knocking at her door. The lady had a very big abscess on her buttocks. Mrs. V. Awoniyi felt compassion towards her and therefore consulted with her husband, Pastor J. D. Awoniyi, who encouraged her to become a Good Samaritan. The lady was treated and the following day, she returned with three other people in need of medical care. The experience was unique in her life; she stated, "I will never forget that day." She quickly attended to them and from that day, her door was open to all and medical services were extended to the indigenous. The College administration headed by Dr. Steward Bekeley contacted the Ile-Ife SDA Hospital about the need to establish a health center. The hospital authorities were very interested and supportive of the clinic that was established in Pastor and Mrs. Awoniyi's house.

Chief Osibodu wanted something more than a clinic in Mrs. Awoniyi's house; he

wanted a real hospital for his people. Therefore, he made a passionate appeal to Dr. Percy Paul, the Principal of the College in 1971. The request was favored by the College administration. Relevant documents were put together and necessary actions were taken for government approval of the health center. Chief Osibodu and his brothers also secured a building (Owodunni House) in the community to house the clinic. In September 1972, the school board voted to have a clinic at Ilishan and on October 8, 1972, the Adventist College Clinic was officially opened.

As the clinic was being established, the landlord of Owodunni House died and conflict broke out among the children, thus affecting the work at the clinic. A decision was then taken by the community and the College administration to look for another site. In 1979, the College clinic was moved from Owodunni House to Sofola House on Irolu Road. Though the place was smaller, the clinic functioned under Dr. Clemonds.

While waiting and hoping for a better place, Chief Osibodu appealed again to the College Administration that the clinic be developed into a hospital. Seeing the unrelenting efforts of Chief Osibodu, Chief Adetola (the Balogun), Mr. J. O. Famodu, and Oba Onasoga made a strong appeal in 1982 for the Adventist Mission to build a hospital at Ilishan. The request was granted and on December 26, 1984, the foundation stone was laid. The main building was completed and the clinic at Sofola House was moved to the new building on the Seminary campus on January 1, 1986. Although the new hospital was relatively small, it continued to provide care for students, staff, and the population of the Ilishan community and its environs for about two decades. In 1999, when ASWA got a charter to operate as a private University, the hospital took the name Babcock University Medical Center.

Under the leadership of Dr. John Sotunsa and committed staff who voluntarily donated part of their salary, a 40-bed hospital extension was completed in 2006. Dr. John Sotunsa, like Chief Osibodu, had a dream. “If Babcock University trains nurses and has a plan to open a medical school in the near future, there has to be some more than 40 beds” (J. Sotunsa, Personal communication, July 19, 2012). Thus, Dr. Sotunsa embarked on a 140-bed extension. The Administration of Babcock University (BU) almost stopped him on the grounds that both the hospital and the University could not afford such a huge project at that time. However, seeing his undaunted faith and the fast rate at which the 140-bed extension was moving, the President/Vice Chancellor of Babcock University, Professor (Pastor) Kayode Makinde, gave him his blessing.

As time went by and the plan to begin a medical school was concluded, the BU administration took over the 140 beds and completed it. In January 2012, BU opened its doors to the first set of medical students and the name Babcock University Medical Center was changed to Babcock University Teaching Hospital (BUTH). Babcock University Teaching Hospital is still at the developmental stage; today, the entire staff of the hospital, excluding the Medical School staff, is about 80, while the daily average patient load is about 25 for in-patient and 80 for out-patient.

Although the hospital from its inception has always taken cognizance of the spiritual component of healthcare, beginning in 2000, there was an increase in the number of BU Theology students visiting the hospital to pray with patients. In 2006, the BU chaplaincy unit began to send staff chaplains to the hospital on a part-time basis.

Statement of the Problem

Babcock University Teaching Hospital is still at a developmental stage. It has not

established an institutional definition of whole patient care, nor has it established an institutional office for the promotion and administration of whole patient care or hired a full-time chaplain. I have been tasked to help develop and establish whole person care at BUTH.

Statement of the Task

The task of this project is to raise awareness, measure attitude, educate, and promote whole patient care at BUTH. The first step in accomplishing this task is to ascertain the level of awareness and the attitudes about whole patient care among physicians, nurses, and hospital patient care personnel and to determine their level of agreement with the need to establish a chaplaincy department at BUTH with whole patient care assignments. The second aspect of the task is to raise awareness by promoting the Seventh-day Adventist definition of whole patient care. The third aspect of this task is to develop the philosophy and definition of whole patient care from a BUTH perspective.

Justification for the Project

Whole patient care includes care for the whole person of the patient and also giving care with the whole person of the caregiver; each involves the complete human: spiritual, emotional, social, and physical aspects that define the human condition (Rice, 2004). Babcock University Teaching Hospital, being a part of the Seventh-day Adventist Church that values and embraces whole person care (White, 1942; Dolson & Spangler, 1975; General Conference of Seventh-day Adventist Ministerial Association, 2005), is seeking a way to understand and establish whole patient care. The abundant research

documenting the positive impacts of spirituality, emotional, social, and physical interaction on patients' health (Carey, 1974; Handzo & Koenig, 2004) also justifies the institutionalization of whole patient care at BUTH. Furthermore, documenting the need for establishing a chaplaincy office as part of the healthcare team at BUTH calls for developing, promoting, and implementing a whole patient care approach at BUTH.

Expectations From the Project

It is expected that this project will; (a) re-awaken and/or create awareness of the significance of whole patient care among BUTH physicians, nurses, and hospital patient care personnel. (b) Further educate BUTH staff in the area of whole patient care. (c) Determine if there is a need to establish a chaplaincy department at BUTH with whole patient care assignments. (d) Help in writing a BUTH version of whole patient care approach. (e) Develop a proposal for the establishment of a chaplaincy office at BUTH.

Delimitation

This study focused on the level of BUTH staff awareness and attitudes to whole patient care in order to be able to achieve the aim of the study documented in the statement of the problem. Although the study focused on awareness and attitudes to whole patient care, it is intended that the study will provide BUTH perspectives on whole patient care.

Limitation

The participants in the study included every staff member of BUTH, both the mainstream medical personnel (doctors, nurses, administrators, physiotherapists, public health officials, chaplains, social health workers, and laboratory officers) and the

supporting staff (housekeepers, record officers, and maintenance officers). Grouping the two categories of staff together may have affected the survey result. Similar studies in the future may have to provide separate training for each employee category. Also, the value the Seventh-day Adventist church places on whole person care, which the staff may have knowledge of, but not necessarily practice (head knowledge), may have influenced the responses staff provided in this survey.

Dividing the participants into two groups may have affected the survey result. Those who attended the first workshop may have influenced the views of those who attended the second.

Since the study is limited to BUTH staff, there is a limit to the extent to which the findings of this study could be generalized; nevertheless, the study could be of benefit to other Seventh-day Adventist hospitals in Nigeria by serving as a platform for subsequent whole person care studies.

Definition of Terms

Whole Patient Care. Whole patient care includes care for the “whole person” of the patient and also giving care with the “whole person” of the caregiver; each involves the complete human. Following Rice, a foremost Adventist theologian of “whole person care” at Loma Linda University, I have embraced the four aspects of his definition of the term “whole person care”: physical, spiritual, emotional, and social. Rice indicated that these four aspects combined define the human condition as presented in the Bible and in the writings of Ellen G. White (Rice, 2004).

The term “whole” is sometimes used interchangeably with wholistic, holistic, or holism. Within the context of this research, I have chosen to use “wholistic” when

referring to what others have called “holistic” and “holism.” The term “wholistic” is the one embraced by Rice and many others in Adventism as opposed to more Eastern or New Age approaches that use the term “holistic” and “holism.” “Wholistic” refers to the integration of the physical, spiritual, emotional, and social aspects of humans when considering them as patients within the healthcare system. Thus, I have adopted as the preferred term for what this project stands for as “whole patient care.”

Health Caregivers. Health caregivers are hospital patient care personnel (doctors, nurses, administrators, and other hospital patient care personnel) who attend directly or indirectly to the health of patients.

Healthcare Chaplains. Healthcare chaplains are chaplains who specialize in hospital ministry. Note: Chaplains in this research work refers to healthcare chaplains.

Description of the Project Process

Biblical reflection centered on (a) the biblical model of Jesus Christ’s ministry, which focused on every aspect of human life—spirituality, emotion, social, and physical—and (b) Ellen G. White’s teachings on wholeness and counsel on care of the sick.

Pertinent literature was reviewed, which included research articles/materials documenting the connections that exist between every aspect of human life—spirituality, emotion, social, and physical. Research articles/materials documenting the positive impacts of spirituality, emotion, and social aspects of human life on health were also examined.

At the beginning of the workshop, a survey (developed from the literature review and adapted to the BUTH experience) was administered to determine the participants' awareness of and attitude to whole patient care.

A training comprised of three sessions with each session lasting approximately two hours was conducted to present (a) the connection that exists between every aspect of human life—spirituality, emotion, social, and physical; (b) positive impacts of spirituality, emotion, and social aspects of human life on health; and (c) a biblical model of Jesus Christ's ministry and Ellen G. White's teachings on wholeness and her counsel on the care of the sick. The workshop presenters were John Sotunsa, MBBS, Director of Clinical Services, BUTH; Johnny Ramirez-Johnson, EdD, MA., Professor of Culture, Psychology and Religion, Loma Linda University School of Religion; and Victoria Aja, MEd, MA., Chaplain, Babcock University.

Focus Group Discussion (FGD) comprised of three sessions with each session lasting approximately two hours was conducted to determine how to contextualize whole patient care in the BUTH setting.

At the end of the lectures and FGD, a survey questionnaire (the same set of questions used at the beginning of the workshop) was administered to determine the influence of the lectures and FGD on participants' awareness of and attitude to whole patient care.

Finally, participants were asked to evaluate the intervention, that is, the lectures and FGD, to determine its relevance to the purpose of the workshop.

The implementation of this project was undertaken between June 2011 and August 2012.

CHAPTER 2

BIBLICAL FOUNDATIONS FOR WHOLE PERSON CARE

Introduction

I see the principle of whole patient care as having divine origin. It is rooted in the word of God (the Bible), evident in the biblical accounts of Jesus Christ's earthly ministry, and supported by Seventh-day Adventist pioneer, thinker, and prophetess, Ellen G. White.

The Bible and Whole Person Care

The nature of man from a biblical point of view helps us understand whole person care. The term *body*, *soul*, and *spirit* have generated a lot of discussion among biblical scholars, particularly on whether the body is a separate entity from the soul. The current SDA views present that, at creation time as recorded in Genesis 2:7 and after God had formed man from the dust of the ground, the body remained lifeless until God breathed the breathe of life into man then man became a living soul; thus, the dust of the ground + the breath of life = a living soul (a living being). The term "soul" translated from the Hebrew word *nephesh* is sometimes used to refer to the whole person or to some aspects of man such as emotions, feelings, affection, and so on. (General Conference of Seventh-Day Adventist Ministerial Association, 2005).

"May God himself, the God of peace, sanctify you through and through. May

your whole spirit, soul and body be kept blameless at the coming of our Lord Jesus Christ” (1 Thessalonians 5:23). The spirit as used in this verse could be interpreted as “the higher principle of intelligence that God bestowed upon man through which God can communicate by His spirit to man” (General Conference of Seventh-Day Adventist Ministerial Association, 2005, p. 95). The soul as used here “may be understood as part of man’s nature that finds expression through the instincts, emotions and desires.” (General Conference of Seventh-Day Adventist Ministerial Association, 2005, p. 95) The Seventh-day Adventist Believe doctrines book indicates that the term spirit (translated from the Hebrew word *ruach*) is sometimes used interchangeably with soul (*nephes*). The body as used in the verse can be understood as the physical body—flesh, blood and bones. One key thing in this verse is that the spirit, soul, and body are all sanctified and are closely woven together—“revealing an intensely sympathetic relationship among person’s spiritual, mental, and physical faculties” (General Conference of Seventh-Day Adventist Ministerial Association, 2005, p. 97). Whatever affects one of the faculties, positively or negatively, will affect the other faculties—“A weak, sick, or suffering physical health will have a detrimental effect on one’s emotional and spiritual health as well and vice versa” (General Conference of Seventh-day Adventist Ministerial Association , 2005, p. 97).

In my reading of the Bible, John’s letter to Gaius revealed that both physical and spiritual health is of equal importance in the simplest and most convincing manner: “Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well” (3 John 1: 2, NIV). Similarly, James established the relevance of spirituality to physical health in a clear manner as presented by the SDA

church. James stated that a sick individual should call on church elders to pray over him or her and that their prayers, offered in faith, would bring healing to the sick individual (James 5:14-15).

The story of the ten lepers recorded in Luke 17:11-19 revealed the principle of wholeness. When the ten lepers approached Jesus for healing, He asked them to go and show themselves to the priest and as they went, in verse 14, they were cleansed (*ekatharisthesan*), which means they were healed of the leprosy. In verse 19, the term “made well/whole” (*sesoken*) was used by Jesus when he spoke to one of the lepers who returned to thank Him (Jesus). Liefeld (1984) explained that the term *sesoken* is more comprehensive than *ekatharisthesan*. Lose (2010) pointed out that regardless of how the word *sesoken* is translated (healed, made well, saved, “Your faith has made you whole”), it is clear that the term implies more than mere healing. Buttrick (1952) alluded to the comprehensiveness of the term *sesoken*. It is a healing that involves the body and the soul. Based on the context, it is obvious that the body referred to here was the physical healing that took place as the lepers went to show themselves to the priest and the healing of the soul was the spiritual healing that was received by the one leper who returned to thank Jesus. Buttrick stated further that the ten lepers were not better people because of the physical cure they received and their failure to return to thank Jesus revealed their sin of ingratitude (which I considered their spiritual need).

It could be said that the moment the ten lepers were cleansed, all received physical, social, and emotional healings—physical (the leprosy went away), social (they could now live among the people and their significant others), and emotional (free from many depressing thoughts about their condition). As implied by Gill (1989), however, the

one leper who returned to thank Jesus received an additional blessing which was spiritual salvation. From the story, it could be said that the whole cure is that which affects the physical, spiritual, social, and emotional aspects of human beings.

Since this research focus is on whole patient care in a Seventh-day Adventist hospital, it is necessary to mention that, in general, Seventh-day Adventists believe that every human being is created whole in the image of God—physically, spiritually, mentally, and socially—and based on 3 John 2; 1 Cor. 6:19; Acts 17:28, and other Bible verses, it is the desire of God that every human being should be in a state of complete well-being (Dolson & Spangler, 1975).

Biblical Accounts of Jesus Christ's Earthly Ministry

Jesus Cared for the Whole Person

Several biblical accounts that documented Jesus Christ's earthly ministry indicated that Jesus cared for the whole person. Jesus addressed the physical, spiritual, social, and emotional aspects of the people He healed and ministered to in various forms.

Jesus Cared for the Physical Aspect of the Human

“Physical” is defined here as the biological body and its various needs and manifestations. This is the way the word is used throughout the document. Mark 1 alone recorded numerous physical healing miracles Jesus performed. Jesus healed many who had various diseases and physical handicaps (fever, leprosy, blindness, dumbness, deafness, etc) and He also drove out many demons (Mark 1:34). In Mark 5:21-34 we find the record of Jesus healing the woman who had suffered a hemorrhage for 12 years, as well as the story of Jesus bringing back to life Jairus' daughter. Further on, in Luke

13:10-17, the record presents how Jesus healed a woman who had been bent over for 18 years. As a chaplain, I see in these narratives Jesus' interest in healing the human body from illness.

In the synagogue in Capernaum, Jesus healed a man who was possessed by an evil spirit (Mark 1:24-29). The event happened while Jesus was teaching in the synagogue. According to Barclay (1994), even though the man interrupted Jesus' teaching (the spiritual matter), Jesus did not chase him out of the synagogue. Rather, Jesus paused and cast out the evil spirit from the man, meaning, suggested Barclay, that Jesus had interest in both the soul and the body. The idea that God cares for the human physical body is seemingly supported by the life and ministry of Jesus as presented by these and many other miracle narratives of healings of the body.

Enumerating all the physical healings Jesus performed during his 33 ½ years of ministry on earth will amount to redundancy. As a chaplain, when I read some of these passages on physical healing that Jesus performed, I see that Jesus was concerned about people's need for food, which suggests that one aspect of physical health is our diet. Upon raising Jairus' daughter from death, Jesus told the parents to give her something to eat (Mark 5:43). Likewise, Jesus had compassion for the large crowd that was waiting for Him: He healed their sickness, preached to them, and fed them (Matthew 14:15-23). The most important fact the above accounts establish is that Jesus cared for people's physical health.

Jesus Cared for the Spiritual Aspect of the Human

“Spiritual” is defined here as the emotional well-being as manifested in human feeling of connection versus distance from God. This definition comes from the work on coping and religion as presented by Gall, Charbonneau, Clarke, Grant, Joseph, and Shouldice—an “indication of spiritual connections to nature, others, and the transcendent” (2005, pp. 94, 95).

As presented by Barker (2002), the narrative of Mark 2 and the miracle presented there was intended to make public (particularly to the Scribes and Pharisees) the deity of Jesus Christ; Rice (2004) also saw in the miracle the acknowledgement of Jesus providing spiritual healing. When the paralytic was brought to Jesus for healing, Jesus addressed his spiritual need (“Son, your sins are forgiven,” Mark 2:5 NIV), as well as his physical need (“I tell you, get up, take your mat and go home,” Mark 2:11 NIV).

As a chaplain, it is important to acknowledge the need for both spiritual and physical healing; thus, the importance of emphasizing how, in this narrative, an indication that the physical and spiritual aspects of humans are closely related and are of concern to Jesus is to be found.

Another story from the Gospels that is key to a chaplain’s ministry and the need to provide spiritual care is found in Mark 5. After stopping her bleeding, (physical healing, in the life of the woman) (Mark 5:25-34 NIV), Jesus also commended her faith: “Daughter, your faith has healed you. Go in peace and be freed from your suffering.” In so doing, Jesus was seemingly ministering to her spiritual needs.

Here spiritual needs are defined by Jesus’ words supporting and commending her action of reaching out and touching her. Similarly, Jesus commended the blind man’s

faith: “Receive your sight; your faith has healed you” (Luke 18:42, NIV). Commending the faith of the bleeding woman and of the blind man was a way of addressing spiritual needs. In other words, spiritual care may be given by commending the already thriving spiritual aspect of the sick.

Jesus Cared for the Emotional Aspect of the Human

According to Shaver, Schwartz, Kirson, and O'Connor (2001), emotions here are defined in relation to the six basic feelings of love, anger, fear, joy, sadness, and surprise. Thus emotions, in this document, refer to the positive (love, joy, and surprise) or negative (anger, fear, and sadness) valence of the feelings any particular human interaction brings up on the individual. Valence refers to the “intrinsic attractiveness” (positive valence) or “aversiveness” (negative valence) of an event, object, or situation (Frijda, 1986, p. 207).

According to Rice (2006), Jesus had concern for people’s feelings and attended to people’s emotional needs. The emotion of shame is an important element in understanding the narrative of John 4:1-28, “the woman at the well.” A chaplain’s reading of the story sees Jesus waiting for her at the well so that He could put an end to her shame which made her come out on that hot afternoon, when no one could see her. That Jesus had concern for human emotions seems evident. First, Jesus created the affront by asking her to bring her husband, thus helping her to understand the magnitude of her problem and of course the need for a deliverer. Then, Jesus followed her conversation line and avoided referring again to the woman’s moral sins by ending the dialogue with a revelation of His true character as the Messiah. In doing so, Jesus

respected the woman even though He openly pointed out her moral sins. This addressed her shame and ministered to her emotional needs.

Jesus Cared for the Social Aspect of the Human

“Social” is defined here as the context of relationships within which the person lives and interacts (Wright, 2008). “Social” is about positive associations as provided and experienced by the individual in the context of support and coping with illness (Wright, 2008).

Jesus understood the importance of community and cared for the social needs of many that He healed: “Each of the individual He raised from the dead was restored to his or her bereaved family—Jairus’ daughter, the son of the widow of Nain, and Lazarus of Bethany” (Rice 2006, p. 39). Healing of the lepers, besides addressing their physical and spiritual needs, also addressed their social need. Customarily, lepers are banished to a leper colony away from family and friends. Thus, restoring them to physical and spiritual health is also restoring them to their community. Telling the lepers to show themselves to the priest (Luke 17:14) was also a way of certifying them fit to mingle with members of their community. Embedded in the physical and spiritual healing was the social restoration.

Similarly, Londis (2009) explicated that the woman with an issue of blood for 12 years (Mark 5:25-34) was in hiding: She sneaked in to touch the hem of Jesus’ garment and she sneaked out, but Jesus insisted on seeing the woman so that she could be restored to her community and to the acceptance of her neighbors. It should be clear that her physical needs were addressed, as well as her emotional and spiritual needs. Thus, the

whole person approach seems to be the method followed by Jesus in emphasizing one aspect at a time. This discussion does not imply that one aspect was addressed, while others ignored.

Jesus Cared With His Whole Person

In addition to caring for the whole person, Jesus cared with His whole person (Rice 2006), using various aspects of His being at different times and sometimes using several simultaneously. To put it in a more concrete way, He gave Himself physically, spiritually, socially, and emotionally.

Jesus Touched People With His Hands (i.e. Physical)

Jesus literally reached out to many of the people He healed (Rice, 2006). As presented by Rice, Jesus took Jairus' daughter by the hand (Mark 5:41) and brought her back to life. A man with leprosy begged Jesus for healing "and Jesus, moved with compassion, put forth his hand, and touched him, and saith unto him, I will; be thou clean" (Mark 1:41, KJV). Further, as recorded in Matthew 20:30-34 (NIV), Jesus touched the eyes of two blind men. "Jesus had compassion on them and touched their eyes. Immediately they received their sight and followed him" (v. 34). "When Jesus came into Peter's house, he saw Peter's mother-in-law lying in bed with a fever; Jesus touched her hand and the fever left her, and she got up and began to wait on him" (Matthew 8:14, 15 NIV).

The literal touch was bi-directional; Jesus touched the sick (as it has been discussed above) and he allowed the sick to touch him. "And when the men of that place recognized Jesus, they sent word to all the surrounding country. People brought all their

sick to him and begged him to let the sick just touch the edge of his cloak, and all who touched it were healed” (Matthew 14:35-36). The woman with the issue of blood also touched Jesus (Mark 5:21-34).

From a chaplain’s point of view, the term *touch* used in the accounts above signifies power and compassion. Power: Then one of the synagogue leaders, named Jairus came, and when he saw Jesus, he fell at his feet. He pleaded earnestly with him, “My little daughter is dying. Please come and put your hands on her so that she will be healed and live” (Mark 5:22-23, NIV). As Jesus touched the sick they received healing, “and the people all tried to touch him, because power was coming from him and healing them all” (Luke: 17-19, NIV). Compassion: A man with leprosy begged Jesus for healing. Jesus had compassion on him and Jesus reached out his hand and touched him (Mark 1:41). Similarly, Jesus had compassion on the two blind men and touched their eyes (Matthew 20:30-34). Jesus’ willingness to touch and be touched is a demonstration of sympathy and love and caring in a concrete personal way (Rice, 2006).

Jesus did not limit His work and Himself to a particular place and people. Jesus whole-heartedly threw Himself into His ministry physically: “But he said, “I must preach the good news of the kingdom of God to the other towns also, because that is why I was sent”(Luke 4:43, NIV). “Jesus went throughout Galilee, teaching in their synagogues, proclaiming the good news of the kingdom, and healing every disease and sickness among the people” (Matthew 4:23; 9:35).

Jesus Gave Himself Spiritually

Jesus gave himself spiritually for the people He ministered to by fasting, praying, and allowing power to flow from Him to the sick. In doing so, He provided connection

with God (the transcendent). This connection allowed those who came in contact with Him to feel whole. While in the wilderness, Jesus fasted for 40 days and 40 nights (Matthew 4:2). The source of Jesus' power to connect people with God came from His own connection with the Father. This personal connection between the Father and His Son Jesus was of primary importance to Jesus. The reason He went into the wilderness and fasted for 40 days and 40 nights "was to be alone with his father and to mediate upon the task that lay before him" (Nichol, 1952, p. 309).

According to E.G. White (1948a), Jesus prayed for His disciples and other believers (John 17:6-26) and before choosing the 12 apostles, He prayed all night (Luke 6:12). Furthermore, Mark 1:35 says that Jesus went to a solitary place to pray. Jesus subjected himself to prayer and fasting for humanity's sake. Thus, the power that Jesus had to connect people to God was completely dependent on and defined by the time He Himself was connected with the Father.

Jesus Gave Himself Socially

"The Son of Man came eating and drinking, and you say, 'Here is a glutton and a drunkard, a friend of tax collectors and sinners'" (Luke 7:34, NIV). Jesus was known as one who socialized, connected, and shared with people. Apart from being concerned about the social condition/need of the sick, Jesus socialized with some of the people He cured of evil spirits and diseases. Among them were Mary Magdalene, Joanna (wife of Cuza), and Susanna. The women followed Jesus from town to town supporting His ministry out of their own means (Luke 8:2). The women were also at Jesus' crucifixion and were the first to learn about His resurrection (Luke 23:55-24:1-10).

Jesus Gave Himself Emotionally

As stated by Rice (2006), Jesus allowed Himself to be touched by other people's feeling and that is proof that He cared with His emotions—Jesus wept (Mark 11:35) and was moved with compassion toward the sick (Matthew 14:14) and the bereaved (Mark 11:33). He also had compassion on those who were hungry (Matthew 15:32), as well as on sinners (Mark 6:34). Jesus is touched by human infirmities (Hebrews 4:11).

The gospel writers paint their portraits of Jesus using a kaleidoscope of brilliant “emotional” colors. Jesus felt compassion; he was angry, indignant, and consumed with zeal; he was troubled, greatly distressed, very sorrowful, depressed, deeply moved, and grieved; he sighed; he wept and sobbed; he groaned; he was in agony; he was surprised and amazed; he rejoiced very greatly and was full of joy; he greatly desired, and he loved. (Hansen, 1997, para. 1)

The Jesus of the Bible is one who experienced negative and positive emotions and engaged appropriately with human interactions, using all basic emotions as defined by Shaver et al. (2001).

Caring for the whole person and caring with the whole person imply that Jesus gave all He had and gave Himself. He took upon Himself human suffering as He became the sufferer. According to Rice, “He [Jesus] poured himself out in service and ministry. Every aspect of his person was devoted to others. . . . Jesus drew on every facet of his life to bless and benefit those around him” (2006, p. 44). This is the model for chaplaincy work and, by and large, whole person care!

Ellen G. White Supports Whole Patient Care

Ellen G. White on Physical and Spiritual Care

The wholeness Jesus practiced in His ministry involved the integration of all aspects of human experience. White said,

Let Seventh-day Adventist medical workers remember that the Lord God omnipotent reigneth. Christ was the greatest physician that ever trod this sin-cursed earth. The Lord would have His people come to Him for their power of healing. He will baptize them with His Holy Spirit and fit them for a service that will make them a blessing in restoring the spiritual and physical health of those who need healing. (1948d, p. 178)

White stressed that Christ demonstrated what true godliness is by ministering to the physical and soul needs (1923, p. 528). When Jesus sent out the 12 and the 70 disciples, He gave them power to preach the gospel and heal the sick and the demonic (White, 1948c, p. 165). Therefore, she advocated that Christian physicians need to carry on Christ's ministry by being co-workers with Him in the healing that addresses both the physical and the spiritual (White, 1990b, p. 36). She also said that physicians and nurses are to make known to all patients who come to the sanitarium, regardless of their status in society, that besides physical healing, they need spiritual help as well (White, 1990a, p. 132). White suggested that those who have grown experientially in the nursing profession, "should seek every opportunity to blend spiritual healing with physical healing because more often than not, those who are sick in body are just about sick in soul, and vice versa" (1990a, p. 406). Here, White presented the close relationships between physical and spiritual healing which was also in line with Jesus' model of healing. As stated by Rice (2006), the words "heal" and "save" came from the same Greek root *sozo* which suggests that both physical and spiritual healing should happen simultaneously. Spiritual healing taking place concurrently with physical healing affirms that spiritual care is an integral part of physical care and from a chaplain's view point, this suggests that under no circumstances should a patient, both in-patient and out-patient, leave the hospital without receiving spiritual care in a manner suitable to the patient's circumstance.

White saw the connection between diet, physical health, spiritual, and mental health. She pointed out that good nutrition is for the well-being of physical, spiritual, and mental health (1954, p. 379). According to White, most of the diseases that plague people today result from bad diet (2004, p. 166). Furthermore, White pointed out that the major reason for establishing SDA health institutions is “to make known to people the importance of a clean, pure, healthful diet—the law of health and principles of health reforms” (1946, p. 446). In addition, she saw as a matter of urgency the need for physicians in SDA medical institutions to inform patients whose ill health emanated from wrong eating and drinking habits to quit such health-destroying habits. She stressed that if such people want to regain their health, they need to abide by the principles of health. Furthermore, White pointed out that wrong eating and drinking habits are not in conformity with God's instructions (1946, pp. 444, 447).

Ellen G. White on Emotional Care

Concerning emotional care, White (1994) stated that Jesus had concern for people's emotions. Besides ministering to the physical and spiritual needs of people, Jesus spoke words of consolation to the troubled hearts. According to White, Jesus' concern for human emotion is very evident in the healing of the paralytic. When Jesus saw the paralytic, He first gave him peace of mind because He knew that the paralytic “had been tortured by the suggestions of the priests that God had cast him off for his sin” (1994, p. 141). In other words, the first thing the paralytic needed was peace of mind. Along the same lines, White wrote that Jesus went about comforting, healing, and relieving the suffering (1877, p. 71).

White noted the close connection between mind and body. She said that the state of one's mind has an effect on the body and vice versa and to further support this connection, she quoted Proverbs 17: 22: "A cheerful heart is good medicine, but a crushed spirit dries up the bones" (1990b, p. 97). White pointed out that depressing emotions such as continuous dwelling on sorrows, troubles, and morbid imaginations are injurious to health. She stressed further that most of the diseases or sicknesses that befall humanity originate from the mind and therefore, she advocated that in treating the sick, the mind should not be neglected (Spalding & Magan, 1983, p. 140).

Ellen G. White on Social Care

The importance of social relationships is documented in White's writings. She described wholesome social relationships as a better way and a powerful tool that can be used to win souls to the Savior (1977, p. 622). She stated that physicians and nurses are to be a fragrance to the sick and when they are, their words and actions will draw the sick to Christ (White, 1990b, p. 88). Another word for fragrance is a sweet smell and I think that by this, White meant a good nature—loving, kind, and so on. She said that "patients should be treated with the greatest sympathy. No physician or helper should contend with a patient, or use harsh, irritating words, or even words not the most kindly, however provoking the patient may be" (White 1948b, p. 170). Furthermore, White stated that knowing that Jesus Christ is a Friend gives more value to the sick as they recover from sickness than the best medical treatment that can be given to them (1942, p. 224). This suggests that friendship is essential when treating the sick.

Ellen G. White on the Whole Person of the Caregiver

As already documented in this study, the whole person of the caregiver is an important component of whole patient care. White (1990b) also echoed its importance as she made references to the ways and manner Jesus cared for the sick and people, in general. She pointed out that Jesus recognized the dignity of humanity by His sympathy and social kindness. He mingled with all people, regardless of class. Jesus worked in His full physical strength to relieve the sick of their suffering. In Capernaum, Jesus did not stop working until the “last sufferer had been relieved” (p. 5). White further stated that in the healing ministry, physicians are co-workers with Christ. This suggests that physicians and, of course, all health caregivers ought to work as Jesus worked—living a life of sacrifice for the sake of others (White, 1948b, p. 210).

Concluding Statement

The general biblical principles on wholeness, the biblical account of Jesus Christ’s earthly ministry, and Ellen G. White’s teachings on wholeness and care of the sick seem to indicate the need to care for the entire human being—physical, spiritual, social, and emotional. The need for the caregiver to care with his or her whole person is also presented as central to whole care. The ministry of wholeness in an SDA hospital can learn from Jesus’ ways by acknowledging the emotional, social, spiritual, as well as the obvious physical needs of patients. In doing so, we will imitate Jesus. Furthermore, the way this ministry will be carried out ought to include the entire individual. Healers cannot give what they do not feel, have, know or believe; as in the time of Jesus, people said, “Physician, heal yourself!” (Luke 4:23 NIV).

CHAPTER 3

EXPLORATION OF LITERATURE PERTINENT TO WHOLE PATIENT CARE

Introduction

In this chapter, pertinent literature documenting the meaning of whole patient care, the connection between the physical, spiritual, social, and emotional, aspect of human being, as well as the positive impact of spiritual, social and emotional on health are reviewed.

Meaning of Whole Patient Care and Connections Between Spiritual, Emotional, and Social Aspects of Human Life

Rabin (2002) indicated how psychological stress can affect the brain and neuroendocrine, cardiovascular, and immune systems. Lakasing and Lawrence (2010) made reference to mind-body connection and how psychosocial issues can impact physical health in their study on when to use reflexology. Marieb and Hoehn (2010) wrote that the organ systems of humans “work cooperatively to promote the well-being of the entire body” (pp. 5, 6). The purpose here is not to discuss in details the anatomy and physiology of human system, but to highlight that every part of the human being is interwoven and that the human being is a whole.

Westgate (1996) argued that in the concept of holism, humans are viewed as functioning as a whole that is closely linked together and that cannot be separated.

Westgate further suggested that spiritual functioning is of equal importance as physical, mental, and emotional functioning. He stressed that when treating an illness or disturbance in one component, one has to understand the effect of the illness or disturbance on the other components. Culbertson (2000) explained wholeness as the interconnection existing between two or more parts in such a way that none of the parts is thought of as functioning independently of the other parts. Based on these definitions of a whole, it could be said that whole patient care suggests full, complete, or unbroken patient care—care that takes into consideration every aspect of the patient. According to Rice, “Every physical problem has emotional, spiritual, or social ramifications, and every emotional, spiritual, or social problem has physical impact” (2004, p. 17). Similarly, Meyerstein (2005) said that illness presents a challenge to the physical, emotional, social, and spiritual aspect of humans so that when ill health is addressed, other aspects of the human must also be addressed. Neely and Minford (2008) pointed out that patients are not synonymous with disease, so they should not be treated as such, but as a whole person. Perez (2009) alluded to whole patient care as treating patients in the body, mind, and spirit.

In the light of the above, whole patient care includes care for the physical, spiritual, emotional, and social aspects of patients. All of the aspects are interwoven, so much so that whatever affects one aspect has implications on the others.

Positive Impact of Spiritual, Emotional, and Social Aspects of Human Life on Health

Defining Spirituality

As research documenting the positive connections between spirituality and health

heightens, scholars continue to query if religion and spirituality are the same or different. According to Murray, Kendall, Boyd, Worth, and Benton (2004), spirituality lacks agreed definition, although policy, research, and practical guidelines for healthcare professionals promote spiritual care as an indispensable component of holistic healthcare. Based on the lack of an agreed definition of spirituality, it is, therefore, necessary to define spirituality when discussing the association between spirituality and health.

The attempt to define spirituality and distinguish it from and link it to religion is important. Puchalski (1999) said that religion is one of the expressions of spirituality. Westgate (1996) pointed out that religiosity and spirituality are distinct and yet overlap. The overlap hinges on the fact that both concepts find expression in the public. Mueller, Plevak, and Rummas (2001) explained that despite the fact that spirituality is a broader concept than religion, both are overlapping ideas. They stressed that search for meaning, higher power, connectedness, and values are common grounds upon which religion and spirituality operate. Neely and Minford (2008) said that spirituality may or may not be connected with a religious organization.

Murray et al. (2004) as well as Puchalski et al. (2009) suggested a contextualized definition of spirituality when discussing the association between spirituality and health which I subscribe to, more so as the analysis of the participants' response to the question "What is spirituality?" falls within the context of overlapping ideas. One of the participants defined spirituality as "Having a relationship with God and being religious." Another participant said he cannot define it, but that he can describe spirituality. He described spirituality as "Opening of one's heart to God, going to church, and doing all that God commanded us to do in his word—the Bible." The idea of having a relationship

with God, going to church, and obeying religious rituals permeated the participants' definition of spirituality. Based on the same idea of overlap, the relationship between spirituality and religion in this document is conceived as part of the same continuum. Therefore, spirituality in the context of this study is defined as having a personal relationship with God and been religious. The literature reviewed for this research included articles on spirituality, religion, spirituality/religion, and health.

Positive Impacts of Spirituality/Religion on Health

Freud said, "Religion is comparable to a childhood neurosis" (1927, p. 53). Immediately before the age of Freud in the 18th and 19th centuries, spirituality was an integral part of health care because of the close association between the church and hospitals; however, when secularization and science became prevalent, some scholars in the field of medical science and related fields began to query the relevance of spirituality to health (Strang & Strang, 2002). Freud described spirituality as an illusion that prevents people from facing reality, while Ellis supposed that religious beliefs are illogical (Hodges, 2002); however, according to Hodges, the relevance of spirituality/religion to health today has been well established.

Handzo and Koenig (2004) stated that the question is no longer whether spiritual care should be part of the medical treatment process. The question has shifted to how spiritual care is to be provided and who should provide it. The statement means that spiritual care is an integral part of medical treatment care. Gall et al. (2005) stated that for over two decades, the interest in research in the area of the association between religion, spirituality, and coping has increased tremendously. Gall et al. opined that the increased interest may be due to the fact that when hard-hit, people turn to religion and spirituality.

Correspondingly, Leeuwen, Tiesinga, Jochemasen, and Post (2007), based on their research findings, stated “spiritual aspects can be of vital importance to patients when they are dealing with their illness..., facing the prospect of death, etc” (p. 488).

Furthermore, Cadge, Freese, and Christakis (2008) pointed out that The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), as far back as 1969, acknowledged in its guidelines the place of religion and spirituality on health care and in 2003, the body categorically stated that hospitals must respect the patient’s religious and spiritual needs and beyond that, inquire about the patient’s spiritual need and conduct spiritual assessment to find ways that a patient’s spiritual/religion preference might affect his care. Neely and Minford (2008) pointed out the importance of ascribing spiritual care as part of the World Health Organization (WHO) definition of a “complete” state of health. The 1948 adopted World Health Organization definition of health indirectly includes the spiritual component of health. “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). The Alliance for Integrative Medicine defined wellness as more than just a state of physical health; wellness encompasses emotional stability, clear thinking, the ability to love, create, embrace change, exercise intuition, and experience a continuing sense of spirituality (Pacific Northwest Foundation, Definition of Health/Wellness, para. 3).

The relevance of spirituality to health is further substantiated as Hamel (2010) enumerated some medical practitioners, scholars, and researchers who have contributed to the association between spirituality/religion and health. Among the contributors Hamel mentioned is Jeft Levin who, in 1987, published a paper entitled “Is There a Religious

Factor in Health.” In the paper, Levin established the connection between spirituality, health, disease, and death. Mentioned also is Harold Koenig who founded the “Center for the Study of Religion/Spirituality and Health” at Duke University. Some other contributors mentioned include David Larson, Michael McCullough, and Larry Dossey.

Based on the positive impact of spirituality/religion on health, numerous medical schools in the United States and the United Kingdom have included courses on spirituality in their curriculum and have made such courses compulsory for all their medical students (Puchalski, 1999; Neely & Minford, 2008; Hamel, 2010). A pilot study of nurses’ experience of giving spiritual care to patients revealed that spiritual care is an important aspect of nursing. Though patients may not necessarily request spiritual care, many of them appreciate it when offered (Deal, 2010).

There is an abundance of empirical research documenting the positive impact of spirituality/religion on health. Mueller, Plevak, and Rummans documented the fact that “a majority of the nearly 350 studies of physical health and 850 studies of mental health that have used religious and spiritual variables have found that religious involvement and spirituality are associated with better health outcomes” (2001, pp. 225, 227). A study by Sorajjakool, Aja, Chilson, Ramirez-Johnson, and Earll (2008) on the role of spirituality and meaning in the lives of individuals with severe depression revealed that spirituality helped depressed patients cope with depression. Balboni et al. (2007) recommended that attention should be given to the spiritual/religious needs of cancer patients who are in the last stage of their lives. The findings of their study showed that 88% of the study population indicated that religion is important to them. The study also revealed a better quality of life among patients whose spirituality was supported by the religious

community or the medical system. Neely and Minford (2008) stated that several studies have reported less frequent high blood pressure and cardiac events and a higher survival rate following heart surgery among people who are committed to religion. Similarly, Holt-Lunstad, Steffen, Sandberg, and Jensen (2011) found positive associations between spiritual well-being and cardiac risk factors.

In a cross-sectional study of 367 men with prostate cancer, a study aiming at developing a theoretical framework of the relationship between religiosity, spirituality, and depression found that spirituality accounted for the most significant reduction in depression. The aspect of spirituality was responsible for having a sense of peace and meaning (Nelson et al., 2009).

It is common knowledge that prayer is a spiritual/religious ritual. Research documented that “as prayer moves more consciously and intimately into relationship with a loving God, the body responds in ways that promote healing, adaptability, and wholeness” (Stanley, 2009, p. 842). Also, a meta-analysis study documented significant positive effects of intercessory prayer on health (Morse, 2010). Morse added that for optimum benefits of prayer, the person praying and being prayed for must relate positively to prayer. Similarly, Smith et al. (2012) documented prayer as a positive coping mechanism among women with advanced ovarian and lung cancer.

It is worth noting that some research findings documented the negative impact of spirituality/religion on some individual well-being especially when spirituality/religion focuses on connection with the transcendent.

Murray et al. (2004) acknowledged that when life is threatened, an individual’s spirituality can be on the down turn, particularly when he/she struggles with existential

issues. Gall et al. (2005) pointed out that painful situations may lead to spiritual struggles, which can be in the form of anger towards God. They said that when spiritual struggle is left unresolved, it can have an adverse effect on the individual's well-being. McCoubrie and Davies (2005) studied the correlation between spirituality, anxiety, and depression in patients with advanced cancer. The result revealed a high level of anxiety and depression among patients who struggle with existential issues. The identified negative impact of spirituality/religion on some individual well-being is not sufficient to negate the positive impact. The role of spirituality/religion, both positive and negative, in health outcomes shows the need for health caregivers to be concerned about the spiritual aspect of patients. As Sorajjakool (2006) pointed out, spirituality/religion is an integral part of humans and as McCoubrie and Davies suggested, "By helping patients to address existential issues, we may improve their spiritual well-being" (2005, p. 384). Moreover, research reveals that spirituality/religion is important to many patients (Balboni et al., 2007; Deal, 2010) and can actually serve as buffer when illness strikes (Koenig, George, and Titus, 2004).

There has been increased inquiry into which aspect of religiosity and/or spirituality is responsible for the positive impact of religiosity and/or spirituality on health. Gall et al. (2005) investigated ways in which spirituality functions to mediate stress. The various ways identified by them are the following:

1. Person Factors (coping resulting from social support provided by religious community and adherence to lifestyles advocated by a religion).
2. Primary and Secondary Appraisals (making sense out of the situation and then attributing the cause to self, chance, other, God, or the devil).

3. Spiritual Coping Behavior (person involvement with organized religious activities such as attending worship and involvement in church activities; non-institutional activities such as prayer and song; and nontraditional spiritual practices such as introspection, helping others, and meditation).

4. Spiritual Connections (being able to cope with situations as a result of having a sense of connection to nature, other living things, and the transcendent other).

5. Meaning-Making (acceptance of the situation as a giving opportunity to learn one thing or the other or grow which, of course, is not limited to those who are connected to the transcendent).

In summary, Gall et al. suggested a model for spirituality/religiosity that includes aspects of relationships as seen in numbers 1, 3 and 4 above, as well as ways for conceiving reality as seen in numbers 2 and 5. These two aspects of relationships and interpretation of reality are seen as the ways by which spirituality/religiosity benefits people in health and wholeness. I believe these two aspects fit perfectly with a chaplaincy model of whole patient care. The aspect of spirituality/religion that positively impacts health is relevant to this study in that in addition to the fact that it demonstrates the positive impact of spirituality/religion on health, it helps health caregivers understand various spiritual interventions.

Positive Impacts of Social Support on Health

Researchers have distinguished between religious-based social supports (social support provided by church/church members) and non-religious-based social support (social support obtained from all other quarters) (Powell, Shahabi, & Thoresen, 2003).

Nevertheless, regardless of the domain, numerous researchers have documented positive associations between social support and coping with illness (Wright, 2008).

Logan, Hackbusch-Pinto, and De Grasse (2006), in addition to indicating reliance on spirituality and God as coping strategies, documented a positive impact of close connections (with relationships) on overwhelming sadness or depression among women undergoing breast diagnostics. According to Logan et al., one of the study participants said,

I never really got a chance to go down enough [get depressed] before I was pulled up again . . . because I have support around me. My husband to start with, who is always with me, and then my sisters; I am not alone, not alone in this. (2006, p. 123)

Logan et al. concluded that nurses can facilitate family members' understanding regarding how they can be of support during the diagnostic period. After controlling for age, severity of medical conditions, and spirituality, Larsen et al. (2006) documented high level of depression among women with heart disease compared to men. The major cause of the depression was traced to the women's concern for social role performance which revolves around fulfilling responsibilities as mother, partner, doing house chores, paid worker, etc. Larsen et al. concluded that psychosocial interventions that address women's social role performance might be of benefit for depressed women with heart disease.

Uchino (2006) documented positive associations between social support and health outcome. He stressed that there is a link between social support and aspects of the cardiovascular, neuroendocrine, and immune systems; and pointed out that the findings are also true for various other diseases. According to Uchino, social support lacks agreeable definition. He identified three forms of social support that are often referred to when discussing its effect on health outcome: Social network (groups, familial ties),

specific behaviors (e.g., emotional or informational support), and perceived availability of support resources that may be shaped early in life. Uchino suggested that there is the need to understand individuals' personality and childhood social and close relationship experiences and that such understanding will help build strong support networks capable of facilitating positive health outcome.

Prince-Paul (2008) pointed out that matters revolving around the social aspect of one's life become very important at the end of one's life. Prince-Paul's study, aimed at determining the impact of communicative acts of love, gratitude, and forgiveness, social well-being, and spiritual well-being on overall Quality of Life at the End of Life (QOLEOL), revealed that the participants' social well-being was not affected by a terminal diagnosis. The finding was attributed to end-of-life care providers who usually, at the initial hospice visit, lay the groundwork of relationships-affirmation and its components. Similarly, Wright (2008), based on clinical and personal experiences with suffering, affirmed the healing influence of social support. Wright stressed that compassion, love, and connection with families as well as connections among healthcare providers, patients, and patients' family members are essential ingredients to facilitate healing.

Furthermore, in a qualitative meta-synthesis study on understanding patients' description and perceptions of their own spiritual needs in healthcare settings, six intertwined themes emerged—meaning, purpose, and hope; relationship with God; spiritual practices; religious obligations; interpersonal connection; and professional staff interaction. Interpersonal connection is described in terms of the need for regular,

compassionate interactions with friends, family, and, in a certain sense, the deceased. The need is further explained as

visiting with family members; conversing with people who share one's spiritual values; receiving prayer from others; seeking forgiveness from people one wronged in the past; processing events with others who had similar experiences; receiving tangible expressions of support and encouragement; being appreciated and loved by other people; and someone's simple, physical presence. (Hodge & Horvath, 2011, p. 311)

The Hodge and Horvath study showed that social support provides succor during times of adversity or illness and also revealed the interrelatedness of social and spiritual aspects of the human being, an interrelatedness that shows that every aspect of the human is connected.

In spite of huge research evidence supporting positive associations between social support and health, it is worth noting that some negative associations have been documented. Seeman's study on the effect of social relationship on older adult mortality risk revealed that social relationships "have the potential for both health promoting and health damaging effects in older adults" (2000, p. 362). Uchino (2006) pointed out that close relationships can sometimes cause stress and encourages unhealthy behavior which can aggravate ill health; nevertheless, Seeman (2000) and Uchino (2006) affirmed the positive influence of social support on health and suggested the need not to ignore its negative potential because of its damaging effects on health. The positive effects and the potential damaging effects of social relationships on health serve as strong supports for the need to take cognizance of the social conditions and social needs of patients.

Positive Impacts of Emotional Support on Health

Cabanac (2002) stated that emotion is often described in relation to feelings of anger, disgust, fear, joy, sadness, and surprise. Cabanac defined emotion as any mental experience that can result in deep or high feelings of pleasure or displeasure. Meyerstein (2005) acknowledged that illness can impact negatively on patients' and patients' family members' emotions. The attending emotions identified include fear, anger, sadness, confusion, and guilt.

Several studies have linked negative emotions to poor health. Everson, Goldberg, Kaplan, Julkunen, and Salonen (1998) showed an association between negative emotion and hypertension. Puchalski (2002) wrote that people who are not ready to let go of their anger, hurt, or resentment towards self and/or others have increased anxiety, go into depression, and have complicated related health issues. She stressed that in the clinical setting, patients who harbor guilt and resentment do not heal fast and have increased and complicated health problems.

Regarding the positive connection between emotion and health, Puchalski (2002) pointed out that people who let go their anger, hurt, and resentment towards self and or others have decreased levels of anxiety and depression. Frisina, Borod, and Lepore (2004) wrote that psychologists have always advocated the positive impact of released emotion on physical and mental health. Frisina et al., using a clinical population, carried out a meta-analysis of the effects of written emotional disclosure on health. The study outcome showed a positive association between expressive written emotional disclosures on health. Similarly, in an experimental study that focused on breast cancer patients, it was found that emotional disclosure, both written and verbal recounting of the

experience, has health benefits, though written emotional exposure documented greater positive effects. Emotional processing is considered a good intervention tool for clinicians (Low, Stanton, & Danoff-Burg, 2006).

Tugade, Fredrickson, and Feldman-Barrett (2004), using the *broaden-and-build theory* of positive emotions as a framework, documented positive correlations between positive emotions, coping with negative events, and positive health outcomes. Richman et al. (2005), using 1,041 patients' records from a multispecialty medical practice, explored the connections between two positive emotions—hope and curiosity—and three physician-diagnosed disease outcomes: hypertension, diabetes mellitus, and respiratory tract infections. Results from the study revealed that positive emotions can prevent development of diseases and brings to a halt the progression of diseases.

Callahan (2009), focusing on the role of social workers concerning end-of-life care, affirmed the health benefit of emotional connection (having a deep genuine relationship with others and healthcare provider). Callahan promoted the need for healthcare providers to connect emotionally with their patients. Farsi, Nayeri, and Negarandeh (2010) explored coping strategies of leukemia patients undergoing hematopoietic stem cell transplantation (HSCT) in Iran. One of the findings of the study documented the efficacy of emotional supports. The study participants reported an improved physical and psychological condition. The participants specifically reported using a social network (family, friends, professional staff, and other patients) as emotional resources for coping. In addition to the findings that positive emotional support can impact health positively, studies by Callahan (2009) and Farsi et al. (2010) also

revealed the symbiotic relationship between the emotional and social aspects of the human, a further support for whole patient care when illness presents itself.

So far, the literature reviewed has established what whole patient care is; the connection between the physical, spiritual, social and emotional aspects of the human being; as well as the positive impact of spiritual, social and emotional on health. Literature on the association between spiritual, social, emotion, and health also alluded to the need for health caregivers to pay attention to/care for the spiritual, social, and emotional aspects of patients. These findings resonate with Chapter 2 which also documented the interrelatedness of physical, spiritual, social, and emotional aspects of human beings and the need for those who have been called into the ministry of healing (health caregivers) in SDA hospitals to embrace whole patient care. Paying attention to/caring for the whole patient raises an important question. When patients arrive at the hospital, it is fundamental that the physical health will be attended to. The question is, whose job is it to care for patients' spiritual, emotional, and social needs?

Whole Patient Care Provider

Whole patient care goes beyond treating presenting illness; it encompasses paying attention to/caring for the spiritual, emotional, and social aspects of patients.

Spiritual Care Provider

Handzo and Koenig (2004) wrote that the question is no longer whether spiritual care should be part of the medical treatment process. The question has shifted to how spiritual care is to be provided and who should provide it. According to Handzo and Koenig (2004), physicians and chaplains are expected to explore and care for the spiritual

need of patients. However, physicians are to do brief spiritual assessment and care while chaplains are to do comprehensive spiritual assessment and care because chaplains have received training in spiritual care. Handzo and Koenig stressed further that physicians can pray for patients and/or address some minor spiritual concerns or needs of patients, but deeper spiritual issues should be left for chaplains to handle and where there is no resident chaplain, physicians need to refer patients' deep spiritual concerns to outside contacts who are trained in spiritual matters.

VandeCreek and Burton (2001) pointed out that though spiritual care is part of nursing practice, nurses may not be able to provide compressive spiritual care for their patients because of the nature of their job, a reality which presents chaplains as the primary spiritual care provider; all the same, VandeCreek and Burton advocated collaboration between chaplains and nurses, as well other healthcare professionals in meeting the spiritual needs of an institution and its customers. Similarly, the Chief Medical Director (Franklin Ani) and Director of Nursing Services (Dorcas Alao) for Babcock University Teaching Hospital (personal communication, July 19, 2012), in an interview with the me on ways spiritual care can be improved at Babcock University Teaching Hospital, pointed out that nurses and physicians do not have sufficient time to carry out in-depth spiritual care for patients. They advocated the services of a chaplain and collaboration among chaplains, nurses, and physicians in the spiritual care of patients.

Furthermore, in a national survey of healthcare administrators' views on the importance of various chaplain roles, there was no disagreement among the administrators concerning the role of chaplains as the spiritual care provider (Flannelly,

Weaver, Handzo, & Smith, 2005). Similarly, Carey and Cohen (2009) acknowledged that the spiritual care of patients is traditionally the job of healthcare chaplains; nevertheless, their research findings revealed that collaboration between physicians and healthcare chaplains is beneficial to patients and clinical staff. One of the benefits identified focused on chaplains providing physicians with useful information about patients' spiritual and ethical issues which, in turn, helps physicians care for their patients holistically.

In summary, the observation concerning the demanding nature of nurses' and physicians' job is noted. Although nurses and physicians may have a form of spiritual care training, they may not have sufficient time and sufficient spiritual training to provide comprehensive spiritual care; however, beyond the demanding nature of the nurses' and physicians' job, the special training in spiritual matters received by chaplains sets them apart as the primary spiritual caregiver, although they are to collaborate with other healthcare professionals in the system.

Social Care Provider

The "Medical social works" (n.d., para. 1) article states that hospital social workers concern themselves with the psychosocial functioning of patients and families in a variety of ways which include, but are not limited to the following: providing supportive or grief counseling, connecting patients and families to appropriate resources and supports within and outside of the hospital, helping patients widen and build appropriate strong network of social supports, and helping in patients' discharge planning.

Like chaplains, social workers do not work in isolation. Cornell Medical Center institution in New York City encourages collaboration between chaplains and social

workers. The institution holds the view that family members often play key role in patients' lives and that collaboration between social workers and chaplains can help family members get around a complex healthcare system, solve problems in a crisis, mobilize them to be positively involved in the patients' recovery, and help them gain access to community resources after being discharged from the hospital. Collaboration between social workers and chaplains is inevitable because the two professions share some common values. Both value patients' narrative (story), the uniqueness of every patient, and patients' freedom to have a say in their treatment plan and the kind of care they receive (Curtis & Matorin, 1997). Social worker collaboration does not end with the chaplains. The "Medical social works," (n.d., para. 2) further article pointed out that social workers work hand-in-hand with other members of the healthcare team who are directly involved in the patient's care.

Emotional Care Provider

Flannelly et al. (2005) conducted a research to understand the importance of chaplain roles and functions in the healthcare setting. The healthcare administrators who participated in the research fell into three categories: directors of pastoral care departments, administrators of hospitals that have pastoral care departments, and administrators of hospitals that do not have a pastoral care department. Among the eleven roles and functions of chaplains identified, providing emotional support to patients was rated by all the three groups of administrators as the second most important role and function of chaplains. Suffice it to say that providing emotional support to patients was second in rating to providing end-of-life-care which, of course, is emotion-laden. The question here is not whether other chaplains' roles and functions are of less value, but

that the most important duty of chaplains is to provide emotional support to patients.

Also, among the identified roles of the social workers is the need for social workers to provide emotional support to patients and their families (Carranza, 2013).

Although the chaplains and social workers, based on their roles and functions, bear the primary responsibility of caring for the emotional aspect of patients, it does not exclude other healthcare team members from paying attention to the emotional needs of patients. According to Handzo and Koenig (2004), while each professional caregiver has a specialty on the healthcare team, each must have an awareness of and concern for the whole person—spiritual, physical, emotional, and social.

The Relevance of Whole Patient Care in the Nigerian Context

In addition to biblical support for and research evidence on whole person care, as discussed so far, the Nigerian cultural context of the majority of BUTH patients further supports the need to provide spiritual, social, and emotional care at BUTH. The majority of the BUTH patients are Nigerians, which, of course, is expected. Nigerians may be perceived as people who derive meaning in life through relationships with others and the transcendent. Larney stated, “Africans place greatest value on relationality” (2006, p. 63). He also stated that “religion and view of transcendence are pervasive and resilient in all of African life” (2006, p. 63). Nigeria is the most populous country in Africa (“The most densely populated country in Africa,” n.d.).

The greatest value Nigerians place on relationship is an indication that BUTH patients would appreciate a care that takes cognizance/addresses the social aspect of their life. Though this research does not focus on practice, it is worth noting that I-thou relationships between BUTH caregivers and their patients, as well as allowing sufficient

contact between family members and patients during hospitalization, may be appreciated greatly by BUTH patients. Uchino's (2006) suggestion that individuals' personality and childhood social and close relationship experience can help build strong support networks capable of facilitating positive health outcomes is highly applicable in BUTH patients' context.

Although Nigerians value relationships, BUTH health caregivers need to discern when a patient/family/friend relationship places a strain on patients' health. As noted in Chapter 3, social relationships have both health promoting and damaging effects.

As noted above, Nigerians' day-to-day living intertwines with religion. Ehuasani said, "The entire life of the African is saturated with a sense of the divine" (1991, p. 207); therefore, caring for BUTH patients' spiritual aspect is crucial. During routine visits or on-call visits to BUTH patients, I often see religious articles such as the Bible, Rosary, Tesbiu, Prayer Cloth or Mat at their bedside. This is also true for other patients around the world, of course. The fact that patients do not leave their spirituality at home when they come to the hospital (VandeCreek, 2004) is true for BUTH patients.

Acolatse (2010), in her research on pastoral care and counseling in independent evangelical charismatic churches in Ghana, observed many African Christians who wandered from one pastor to another seeking for a spiritual cure for physical, psychological, relational, or spiritual illnesses. She pointed out that these African Christians believe that their problems or illnesses are brought on them by their enemies, which means they believe that they are bewitched. Based on my chaplaincy ministry experiences at BUTH, Acolatse's finding is founded; I would add that seeking a spiritual cure for physical and other forms of ills is not limited to Christians alone. It cuts across

Christians, Muslims, traditional believers, and non-believers, as well. Some patients have opened up to me on how they have gone from one pastor to another, seeking a spiritual cure for their physical illness. For example, a patient's mother (a Christian) recently narrated to me the genesis of her son's psychiatric problem and how she had gone from one church to another seeking for cure. I also met a male patient (a Muslim) in his mid-60's who had a wound that seemed, at the time, unresponsive to treatment. On my fourth visit to him, he told me that the wound was as a result of the work of his enemies and that he appreciated my praying for him.

Being a Nigerian, I can agree that bewitchment is real, but it is not the genesis of every physical or psychological illness. As pointed out by Acolatse, providing spiritual care would help to distinguish between patients' problems that are purely somatic from those somatic problems related to witchcraft. Combining physical and spiritual care, in addition to benefiting all patients, is likely to have an added advantage to BUTH patients who have the notion that they are betwitched or who are actually betwitched.

As stated above, the praxis of whole patient care (i.e. details of how to provide spiritual, social, and emotional care) is beyond the scope of this study. Thus, suffice it to mention here that the BUTH chaplain and social worker, as primary spiritual and social caregivers respectively, need to provide spiritual and social care for BUTH patients and staff that take into consideration the value Nigerians place on relationships and the connectedness between Nigerians' day-to-day living and religion.

Concluding Statement

To begin with, the literature reviewed revealed that more studies have been done on whole person care in developed countries. Therefore, this current study will add to the

body of knowledge in Nigeria, a developing country, in the area of whole patient care. Thus, whole patients care, based on the literature reviewed, is relevant in the Nigerian context.

Furthermore, the biblical principle on wholeness, the account of Jesus Christ's earthly ministry, E. G. White's teachings on wholeness and care of the sick discussed in Chapter 2, and the literature reviewed in this chapter suggest that there is a connection between spirituality/religion, social, emotion, and physical aspect of human. The positive effect of spirituality/religion, social, and emotion on health was also well documented. It is now understood in the medical sciences that the human is a whole with various aspects; whatever affects one aspect of the human has an implication on all other aspects.

In addition, the literature reviewed points to the conclusion that the specific roles and functions of a chaplain and a social worker are as the primary spiritual care provider and social care provider, respectively. The literature reviewed also points to the chaplain and social worker as the emotional care providers. The need for each healthcare professional on the patient care team to collaborate in the provision of wholistic care was also clearly suggested. Whole patient care ought to be an important part of healthcare establishments, based on the merits of the benefits of whole patient care as revealed by the literature reviewed, including the biblical principle on wholeness and the account of Jesus Christ's earthly ministry and E. G. White's teachings on wholeness and care of care the sick.

CHAPTER 4

DEVELOPMENT AND IMPLEMENTATION OF WHOLE PATIENT CARE WORKSHOP

Introduction

This chapter describes the development of the workshop and the methodology employed in this study. The chapter also presents the implementation narrative.

Development of Workshop

The development of the workshop began with sharing my knowledge in Healthcare Chaplaincy Ministry and whole patient care with the Director of Clinical Services for BUTH. At the meeting, it was revealed that BUTH had not established a contextualized institutional definition of whole patient care or an institutional office for the promotion and administration of whole patient care, nor hired a full-time chaplain. Therefore, the Director of Clinical Services asked me to help develop and establish whole patient care at BUTH. This task, as well as the value the SDA Church places on whole person care (Dolson & Spangler, 1975) prompted me to seek to investigate the awareness and attitude of BUTH health caregivers to whole patient care.

To achieve the task, I consulted with my project supervisors and the Director of Clinical Service on the viability of organizing a two-day workshop aimed at creating awareness of the importance of and the need to develop whole patient care at BUTH.

Having agreed that conducting a workshop was viable, approval was sought and received from the BUTH Ethical Committee and Andrews University Institutional Review Board (IRB). Subsequently, the research proposal was approved by the Seventh-day Adventist Theological Seminary at Andrews University.

Beginning six weeks before the workshop, with the permission of the BUTH Administration, I made regular announcements concerning the workshop at the BUTH staff daily morning devotional meetings. I encouraged the staff present at the devotion to inform those staff who were likely to be absent at the morning devotionals about the workshop. The regular announcement concerning the workshop included the date, venue, nature, and purpose of the workshop. The staff members were also made to understand that the workshop was for the entire staff, regardless of line of work, gender, age, position, years of service, and so on and that participation was voluntary. Two weeks before the workshop, with the assistance of the BUTH Administrative Secretary, invitations (See APPENDIX A) were sent out to the entire staff. The Secretary was also asked to compile the list of those who had indicated interest. The entire staff indicated interest with exception of a few who were on annual leave and had travelled out of town. A week before the workshop, I personally gave the consent form (See APPENDIX B) to those who had indicated interest and explained the purpose and nature of the workshop. Those who had indicated interest were given the option of attending one of the two workshops. This was because of the nature of their work—the hospital had to keep running while the workshop was going on. The workshop was repeated after one week. Thirty-one (31) staff members were present at the first workshop, while 35 were present at the second, making a total of 66 individuals.

No monetary incentive was given to participants; however, food, water, and soda were provided to participants because of the length of the workshop. The first day of the workshop lasted approximately eight hours and the second day lasted approximately seven hours. Each participant was also provided with the program of events (See APPENDIX C), a jotter, and a pen.

Development of Methodology

Research Design

This study adopted a quantitative (survey) and qualitative (Focus Group Discussion) mixed methods research design.

Quantitative Method

A survey questionnaire on awareness and attitude of whole patient care for doctors, nurses, and hospital patient care personnel, developed from the literature, reviewed and adapted to the BUTH experience, was used to elicit information regarding participants' awareness of and attitude to whole patient care before the workshop. At the end of the workshop, the same questionnaire was used to determine the influence of the workshop on participants' awareness of and attitude to whole patient care.

The questionnaire was divided into two sections. Section A elicited information on the demographic variables. Section B contains 27 items (See APPENDIX D) and covered items related to whole patient care. The 27 items in the survey were grouped into 7 categories that represented the seven aspects of whole patient care: (a) Have a residence chaplain and a functional chaplain services at BUMC, (b) health caregivers need to ask patients about their spiritual well-being, (c) health caregivers need to ask patients about

their social well-being, (d) establish a social worker office, (e) health caregiver needs to care for the emotional needs of patient; (f) provide nutritious food for patients, and (g) provide adequate medical care for patients. The categories were known only to the investigator for the purpose of data analysis.

The items on the survey questionnaire were scored on a Four-Point Likert Scale: Strongly Disagree (1), Disagree (2), Agree (3), and Strongly Agree (4).

Qualitative (Focus Group) Method

The Focus Group Discussion (FGD) approach was used to determine how to contextualize whole patient care in the BUTH setting. Participants were divided into three groups and each group was asked to respond to the following tasks/open-ended questions:

1. What are the factors influencing whole patient care at BUTH?
2. Develop strategy on ways to improve whole patient care at BUTH.
3. Develop an on-going strategy for regular training.

The Study Population

The study population was the entire group of staff members of BUTH. A sample of sixty-six (66) staff members participated in the study. Of these, 54 participants completed the survey accurately, that is, they completed the questionnaire before and after the workshop. This gave us an 81.81% participation rate (54/66). The participants were comprised of administrators (also members of staff in the various department of the hospital), doctors, nurses, physical therapists, laboratory workers, medical record

workers, ground keepers, housekeepers, campus chaplains, public health workers, pharmacists, maintenance officer, and social health workers.

Validity and Internal Reliability

The development of the interview guide was based on the literature reviewed and the guidance of my supervisors. A nurse practitioner who had served in all the three main Seventh-day Adventist Hospitals in Nigeria was also asked to respond to the items to see if any of the items was considered ambiguous or if anything of importance in the area of whole patient care was left out. The review carried out by the nurse led to the inclusion of eight items in the interview guide (items 20-27 which focused on provision of nutritious food and adequate medical care for patients). The internal reliability of the survey was also carried out; the Cronbach's Alpha was 0.735. To this end, the face validity and internal reliability of the survey were ascertained.

Data Analysis

Quantitative Data

Fifty-four participants completed the survey questionnaire before and after the workshop. The 27 items on the survey questionnaire were grouped into seven categories representing the seven aspects of whole patient care. Salem Dehom, research consultant at Research Consulting Group, Loma Linda University and Rachel Mbassa, Biostatistics student, Loma Linda University School of Public Health, were consulted for the statistical analysis of the data.

For the quantitative variables, descriptive statistics were performed using IBM SPSS (Version 20; IBM Corporation 1989, 2011). Descriptive statistics are presented as

mean \pm standard deviation and number with percent. A paired-samples t-test was performed to test the extent to which the workshop influenced the participants' level of awareness and attitude to whole patient care through a comparison of the overall means of index score before and after the workshop. For each of the categories, the Wilcoxon Signed-Rank test was used when the assumptions of paired-samples t-test were not met. Bar charts were used to visually display the mean score for the overall and each of the seven categories. Alpha was set at 0.05 significance level.

Qualitative Data

For the qualitative data, Morgan's (1998) suggestion of analyzing data that is note-based was adopted in analyzing the FGD proceeding. First, a summary of each focus group report was prepared. Second, a summary of the notes taken during the groups' presentations of report was prepared, and third, the two summaries were read through several times for emerging themes.

Since I was a staff member of BU/BUTH and in order to minimize my biases/assumptions in the interpretation of the qualitative data of this research, I asked clarification questions when any statements made by participants (during the presentation of reports by the Focus Group and general discussion by the participants) seemed vague. This was necessary because in qualitative research, researchers' pre-understanding and prejudices raise the question of credibility and trustworthiness of research findings (Swinton & Mowat, 2006). As cited in their text, Swinton and Mowat (2006) rejected Corber's (1999) idea of bracketing researchers' pre-understanding and prejudices for the purpose of credibility and trustworthiness of research findings; they argued that it is not possible for researchers to remain in a state of complete neutrality and objectivity.

Swinton and Mowat opined that pre-understanding and prejudices have a way of deepening the researchers' understanding. Pre-understanding and prejudices allow researchers to discuss back and forth and ask concrete questions that clarify the situations or the issue being studied.

Analysis of Workshop Evaluation Questions

A descriptive percentage analysis was used to determine the participants' response to each of the four evaluation questions. The "workshop evaluation questionnaire on awareness and attitude of whole patient care for doctors, nurses, and hospital patient care personnel" was designed to help determine if the workshop presentations addressed the workshop's main objectives and if it had an impact on the person and profession of each participant. The workshop evaluation questions are shown in Table 1:

Table 1

Workshop Evaluation Questions

The workshop addressed its main objectives	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
The workshop is timely in the history of Babcock University Medical Center	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
The workshop has a positive impact on my person	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
On a scale of 1 – 10 (10 being the greatest value) rate the felt impact of the workshop on your profession	1 2 3 4 5 6 7 8 9 10

As shown above, items 1-3 on the evaluation questionnaire were scored on a Four-Point Likert Scale while item 4 was scored on a scale of 1-10.

Implementation Narrative

The workshop took place at the BUMC Chapel, otherwise called Siloam Valley (See APPENDIX C for program of events).

Day 1

The day began with an official opening ceremony of the workshop. The opening ceremony started at about 9:00 am and ended at about 10:00 am. Present at the opening ceremony were the workshop participants and resource persons and some officials of Babcock University (Senior Vice-President, Representative of the Vice-President for Finance, Head of Religious Studies Department, University Church Pastor, Director of Chaplaincy Unit, Director of Research and International Cooperation and his Deputy).

The opening ceremony was designed to create the enabling environment for the principal officers of BU to become familiar with the project. BU Administration is my employer and has an interest in my Doctor of Ministry program. Not only that, BUTH is an entity of BU. The opening ceremony was also designed to welcome Professor Ramirez-Johnson, one of the workshop resource persons, who came from Loma Linda University, California, USA. Last, but not least, the opening ceremony was designed to pray to God for the success of the workshop.

At the opening ceremony, I welcomed the participants and invited guests and clearly stated the purpose of the workshop. Next, the Senior Vice-President for Babcock

University welcomed Professor Ramirez-Johnson and gave the opening speech. Professor Ramirez-Johnson responded to the warm welcome extended to him and his wife. This was followed by a prayer session. The University Pastor prayed for the success of the workshop and also offered a dedicatory prayer for the religious tracts I printed for use in the hospital (I got the concept of using relevant religious tracts/literature in the hospital from Loma Linda University Medical Center where I did my Clinical Pastoral Education (CPE). After the prayer, the workshop was declared open by the Senior Vice-President for Babcock University. A group photograph concluded the opening ceremony (See APPENDIX E). Immediately after the photograph was taken, the workshop participants re-convened.

At the workshop, participants were asked to respond to the survey questionnaire on awareness and attitude of whole patient care for doctors, nurses, and hospital patient care personnel. To ensure privacy (confidentiality), participants were asked not to write their names on the questionnaire; however, in order to be able to match each participant's responses to the questionnaire before and after the workshop, each participant was given a number which he or she was asked to keep in mind as it would be used for subsequent surveys. After the participants had responded to the questionnaire, the completed questionnaires were collected and the lecture/training session commenced.

The lecture/training was comprised of three sections. Each session lasted approximately two hours. After the first two lectures/trainings, participants were given a one-hour lunch break and after the lunch break, participants reconvened for the last lecture/training of the day. Shown in Table 2 are the topics of the lectures/trainings and the presenters/resource persons:

Table 2

Topics and Presenters

Topics of the Lectures/Trainings	Presenters/Resource Persons
1. The connection that exists between every aspect of human life—spirituality, emotion, social, and physical.	John Sotunsa, M.B.B.S., and Acting Medical Director, BUTH
2. The positive effect of spirituality, emotion, and social aspects of human life on health.	Johnny Ramirez-Johnson, Ed.D., M.A, Professor of Culture, Psychology and Religion
3. Biblical model of Jesus Christ's ministry and Ellen G. White's teachings on wholeness and her counsel on the care of the sick.	Victoria Aja, M. Ed., M.A., Chaplain, BU

Each lecture/training was interactive as participants and presenters asked questions to clarify issues and facilitate understanding. Also, each presenter made use of a projector as a teaching aid. At the end of the lectures, participants were given the lecture materials. Day 1 of the workshop ended with a closing prayer and participants were reminded to keep in mind their assigned number.

Day 2

Day 2 of the workshop began at about 9:00 am. I welcomed the participants and introduced the day's activity as Focus Group Discussions (FGD). The program began with a 20-minute morning devotional by Dr. Ramirez-Johnson. Following the devotional,

participants were divided into three groups. As much as possible, each group was made up of representatives of staff from every division of the hospital present in the workshop. Each group had a coordinator and a recording secretary. Each recording secretary was asked to record verbatim, as much as possible, each participant's contributions. Each group was asked to deliberate on how to contextualize whole patient care in BUMC. The three open-ended tasks/questions each group deliberated upon were:

1. What are the factors influencing whole patient care in BUTH?
2. Develop strategy on ways to improve whole patient care at BUTH; and
3. Develop an on-going strategy for regular training.

Every participant was encouraged to participate in the discussion. The discussion session began at about 09:30 am and lasted for three hours, after which the participants re-convened. At this point, water and refreshments were provided for the participants. Each group's recording secretary presented his/her report to all the participants, one after the other. The participants were given the opportunity to ask clarification questions and were asked to note their contributions. After all the three groups had presented, their written reports were handed over to me. Following this, the participants were told to make their contributions, ask questions, and clarify questions if there were any. I wrote down the contributions and additional points generated by the questions and clarification questions asked. The group presentations lasted for about four hours.

At the end of the FGD activities, each participant was given a fresh questionnaire to fill out with (the same set of questions used at the beginning of the workshop. Each participant was reminded to write his or her indentifying number on his or her questionnaire. When the completed questionnaires had been collected and put away,

participants were asked to evaluate the workshop by completing a questionnaire marked “Workshop evaluation questionnaire on awareness and attitude of whole patient care for doctors, nurses, and hospital patient care personnel.” As stated above, the purpose of the evaluation was to determine if the workshop presentations addressed the workshop’s main objectives and if it had an impact on the person and profession of each participant. Day 2 ended with my vote of thanks and closing prayer by one of the participants.

Concluding Statements

This study was designed to create an awareness of the importance of whole patient care among BUTH health caregivers and to obtain data for the purpose of establishing whole patient care at BUTH. This project is the first in the area of exploring the awareness and attitude of health caregivers to whole patient care in the healthcare setting at BUTH. There is abundance of research on the connection between physical, spiritual, social, and emotional aspects of human life, as well as the positive impact of spiritual, social, and emotional aspects of human life on health. There is some research on whole person care, but none specifically explored awareness and attitude of health caregivers to whole patient care in the healthcare setting. Therefore, there was no pre-existing survey instrument to copy or adapt for this study. The survey instrument for this study was freshly developed from the available literature reviewed and adapted to the BUMC experience. Nevertheless, the validity of the data and this study in general was not compromised. The face and content validity (internal reliability) of the survey instrument was ascertained. This study was also approved by the Andrews University Institutional Review Board (See Appendix F) and the Babcock University Ethical

Committee (See Appendix G) and the research proposal was approved by the Research Coach for Andrews University Theological Seminary.

CHAPTER 5

ASSESSING THE WHOLE PATIENT CARE WORKSHOP:

OUTCOMES AND EVALUATION

Introduction

In this chapter, the results of the study are presented. I posited that this study would help participants understand better the importance of whole patient care. I intended that the study would serve as a foundation for developing whole patient care at Babcock University Teaching Hospital (BUTH) as well as help in writing the BUTH philosophy and application of whole patient care. I proposed that carrying out the workshop and writing the report (the project) would help improve my research and chaplaincy ministry skills.

I expected that combining quantitative and qualitative research methods to explore BUTH health caregivers' awareness of and attitude to whole patient care would indicate the overall impact of the workshop on the participants. I also expected that the evaluation of the workshop by the participants would be related to the felt impact of the workshop as an indication of the health care workers' level of support for further whole patient care projects at BUTH.

I expected that the overall mean score after the workshop would be higher than the mean score before the workshop. These differences in mean scores before and after the workshop would suggest whether the healthcare workers embraced the whole person

care philosophy and methods. I expected that there would be variations in the mean for each of the seven categories after the workshop and that the mean for each of the seven categories after the workshop would be higher than the mean before the workshop.

Quantitative Outcome

As stated earlier, this study used quantitative and qualitative (Focus Group Discussion) mixed method approaches. Fifty-four (54) out of 66 participants who attended the workshop completed the survey questionnaire before and after the workshop. The 27 items on the survey were grouped into seven categories representing the seven aspects of whole patient care that the 27 items addressed. The entire 66 participants took part in the Focus Group Discussion (FGD).

The descriptive result, as shown in Table 3, implied that the overall mean score for the 27 items after the workshop was higher than the mean score before the workshop ($p < 0.05$). The mean scores for categories 1, 2, 3, 4, and 5 after the workshop were higher than the mean score before the workshop ($p < 0.05$). For category 6, the mean score after the workshop was slightly higher than the mean before the workshop, but not significant ($p > 0.05$). Category 7 showed a significant decrease in the mean score after the workshop ($p < 0.05$).

Table 3

Mean Scores Before and After the Workshop (N=54)

	Time						
	Before			After			P-value
	N	Mean	Standard Deviation	N	Mean	Standard Deviation	
Overall	54	3.08	.24	54	3.16	.26	0.020
*Category 1	54	3.37	.50	54	3.50	.44	0.026
*Category 2	54	3.33	.40	54	3.48	.42	0.009
*Category 3	54	3.28	.42	54	3.51	.47	0.001
*Category 4	53	3.07	.47	53	3.27	.46	0.023
*Category 5	53	2.78	.48	53	2.98	.49	0.001
*Category 6	53	3.07	.51	53	3.12	.50	0.525
*Category 7	53	2.71	.43	53	2.46	.51	0.004

*Category 1 – Have a chaplain in residence and functional chaplain services at BUMC

*Category 2 – Health caregivers need to ask patients about their spiritual well-being

*Category 3 – Health caregivers need to ask patients about their social well-being

*Category 4 – Establish a social work office

*Category 5 – Health caregivers need to care for the emotional needs of patient

*Category 6 – Provide nutritious food for patients

*Category 7 – Provide adequate medical care for patients

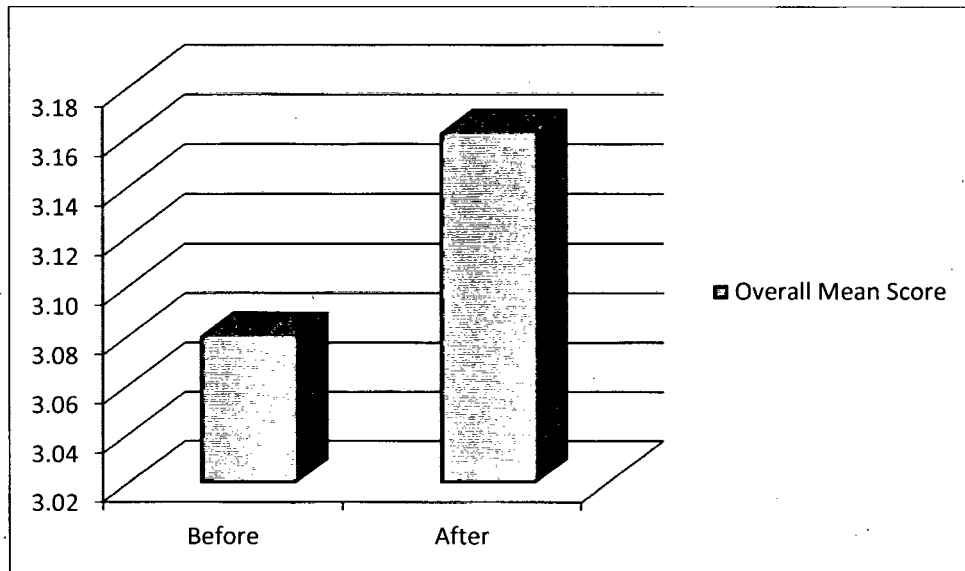


Figure 1. Overall (i.e. the sum of all 27 items) mean score before and after the workshop

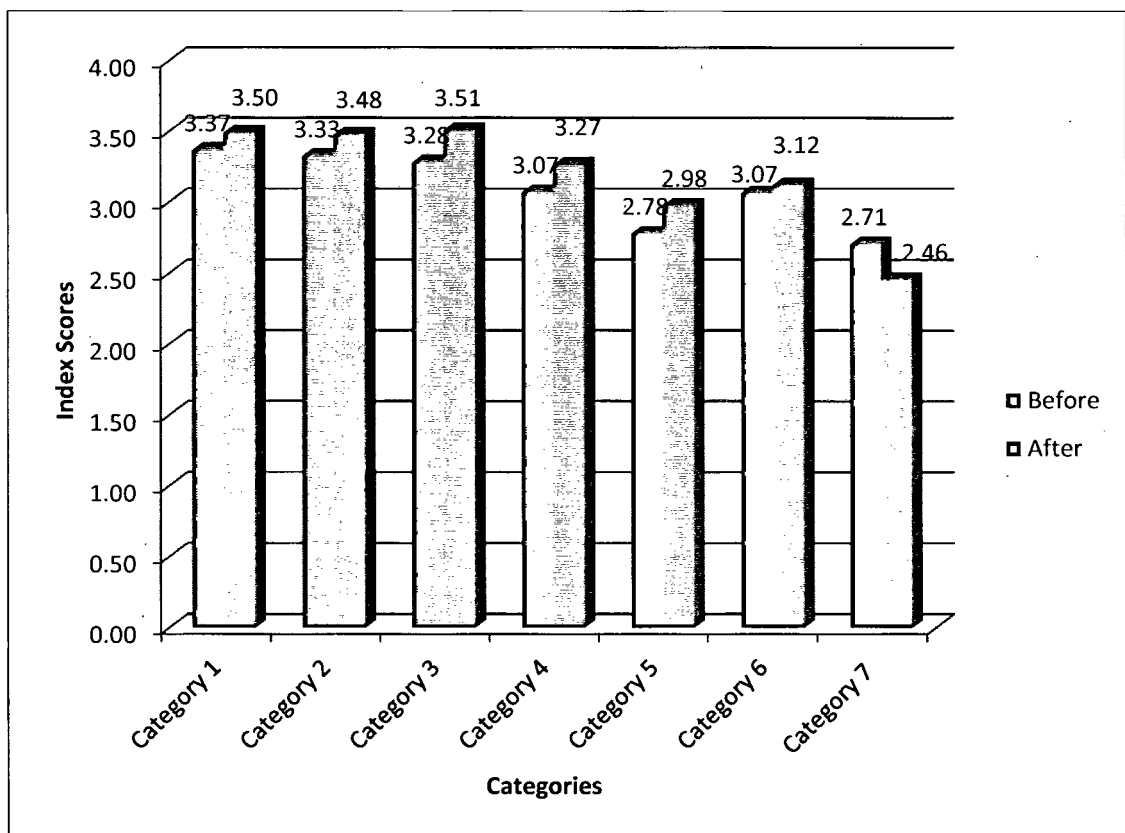


Figure 2. Mean index scores before and after the workshop for the seven categories

Qualitative Outcome

Morgan's (1998) suggestion on analyzing data that is note-based was adopted in cogitating the FGD proceedings. Based on the analysis of the Focus Group Discussion (FGD) data, a number of themes or categories emerged: high medical bill, staff welfare and motivation, shortage of manpower, lack of chaplain in residence, staff/patient relationship, family/staff relationship, staff to staff relationship, leadership attitude, environmental factor, feeding of in-patients, proper orientation of new employee, provision of necessary tools, emotional care, orientation of new employee, regular staff training, regular staff meeting, social worker job description, and inadequate medical equipment, evaluation (see Table 4: Sample Qualitative Categories Statements from Participants). In the evaluation of the outcome of the study, some of the details will be presented as they relate to the physical, spiritual, social, and emotional care of patients.

Table 4

Sample Qualitative Categories Statements from Participants

Emerged Themes	Sample Quotes
High medical bill	<i>"When we want to show that we are concerned about their well-being, they may not take us seriously because of the high price"</i>
Staff welfare and motivation	<i>"There was nothing to motivate staff to take extra time to pay attention to other aspects of patients"</i>
Shortage of manpower	<i>"Increasing workforce especially nurses, physicians and other health workers, would reduce workload and staff would have enough time with patients and be able to attend to their needs in all aspects of their lives."</i>
Lack of chaplain in residence	<i>"Let the hospital hire full-time female and male chaplains."</i>
Staff/patient relationship	<i>"There should be a good relationship between staff and patients; there should be one-on-one interaction with patients in order to know about their emotional and other needs."</i>
Family/staff relationship	<i>"Family is important because they take care of the patients. If a family is treated rudely, the patient will not be happy and that may affect the health of the patient."</i>
Staff to staff relationship	<i>"Attitude of health workers to one another in the area of achieving team work is an integral way of meeting the patient's need."</i>
Leadership attitude	<i>"Administrators should enroll in leadership training; leadership must ensure that staff carry out whole patient care; staff must be mandated to give a report of care provided to patients, [and] there must be proper implementation of FGD suggestions."</i>
Environmental factor	<i>"The environment is not tidy; for example, the lawns are always bushy, the wards and O.P.D [Out Patient Department] are congested, and the air is polluted since the community dumpsite close to the hospital."</i>

Table 4—Continued.

Feeding of in-patients	<i>“The type of food some family members bring for their sick loved ones sometimes has adverse effects on the patients’ health. The hospital should hire dieticians or nutritionists who can plan their [patients’] diets.”</i>
Provision of necessary tools	<i>“Provision of inter-communication device and computers will make work less stressful and thus, staff would have more time to relate with patients.”</i>
Emotional care	<i>“The emotional aspect should be taken care of by the nurses, doctors, and chaplain.”</i>
Orientation of new employee	<i>“Every new employee should receive training on whole patient care.”</i>
Regular staff training	<i>“Regular information/education on the importance of whole patient care and follow-up of the training (that is, people who are not present during this training should get the information)... this current training should be modified and be tailored to the context of each category of workforce so they can benefit more.”</i>
Regular staff meeting	<i>“There is the need for regular departmental and general meetings and follow-ups on each staff practice of whole patient care.”</i>
Social worker job description	<i>“Let the social worker work as a social worker and not as a public health officer.”</i>
Inadequate medical equipment	<i>“We lack sufficient equipment. There should be generators, autoclaving machine, x-ray machine, dental chair, and washing machine.”</i>
Evaluation	<i>“At the end of the year, write your report; submit your report of your practice of whole patient care.”</i>

Although the table above contains all the themes or categories that emerged from the analysis of the FGD, the table does not contain all the references made to each of these categories; only a sample was chosen to illustrate each one. The themes or

categories that emerged, although taken into consideration in the writing and analysis of this study, were not all used and quoted as part of the text. The themes used were chosen for their direct import on the analysis conducted.

Evaluation

It should be noted that all demographic indications such as gender, healthcare role, and position have been changed from the true identity while retaining the same number of categories and gender representation. Thus, full anonymity has been preserved. As expected, the overall mean score for the 27 items and the mean score for each of the seven categories after the workshop were higher than the mean score before the workshop with the exceptions of category 7. The mean for category 7, although lower after the workshop than before, were in harmony with the overall outcome as I explained below.

Category 7 focused on the provision of adequate medical care for BUTH patients. The bulk of the items in this category explored whether BUTH provides adequate care for its patients. In the analysis of the data collected *before* the workshop, the participants felt that BUTH provided adequate medical care for its patients, but *after* the workshop, the participants' opinions moved in the opposite direction. This suggested that more participants wished for improved medical care as a result of embracing whole patient care approaches *after* participating in the workshop than *before*.

Overall, the analysis of the data, both quantitative and qualitative, suggested that participants understood the importance of whole patient care and that the workshop had a positive impact on the participants' awareness of and attitude to whole patient care. The analysis of the workshop evaluation survey (See APPENDIX H for details) also

seemingly indicated that a majority of the participants “agreed” and “strongly agreed” that “the workshop addressed its main objective,” “is timely in the history of Babcock University Teaching Hospital,” and had a “positive impact” on their person and profession.

In summary, it seems that the participants saw the need to care for the physical, spiritual, social, and emotional aspects of patients and perceived the workshops as helping in this purpose. As stated in Chapters 2 and 3, the physical, spiritual, social, and emotional are all part of my definition of “whole patient care.” Thus, the next section of this document will analyze what we learned from the FGD divided into four aspects of care: physical, emotional, social, and spiritual.

Participants and Patients’ Physical Care

A female physician participant said, “We lack sufficient equipment. There should be generators, autoclaving machine, x-ray machine, dental chair, and washing machine.” This physician participant of the FGD seemingly wished for better physical care for the patients via better equipment that could serve the physical aspects of the care provided. Other participants identified “insufficient medical equipment” and “lack of equipment” as factors negatively affecting physical care at BUTH. The state of equipment in Nigerian medical facilities was recently expressed by a consultant who worked at the State Specialist Hospital and who request anonymity in order to protect his identity. As reported by Madike (2012) in the National Mirror, the consultant said,

Almost 70 percent of the government hospitals across the state lack the required medical facilities. In most cases, common drugs are not available for patients to buy from the hospitals. Some hospitals do not even have a single medical doctor, and some of the few nurses available cannot cope with the modern day challenges experienced in the health system.” A patient at the male ward of the State Specialist

Hospital, Mallam Abba Usman, also confirmed that the service delivery in the hospital is very poor. “The toilets are in bad shape; there is also lack of regular supply of electricity in the hospital. Here, relatives buy drugs from outside pharmaceutical shops, as there are no drugs in this hospital and there are cases of decomposing corpses at the mortuary. (par. 11)

The perceived need for appropriate equipment in providing medical care for patients was seemingly integrated in the definition of proper physical care of patients as part of whole patient care. In the healthcare worker’s words, values and feelings were assigned to the perceived lack of an adequate number of personnel. A male nurse participant identified the professional competency of the hospital personnel as a challenge and suggested hiring competent staff. He said, “*Staff should handle patients’ cases in which they have expertise and are naturally and intellectually endowed.*” This critical statement poignantly expresses a frustration with the current state of affairs while also strongly suggesting the positive image and vision the provider has for the future of BUTH.

Participants pointed out the negative impact of an untidy environment on patients’ physical health. A medical records officer stated, “The environment is not tidy; for example, the lawns are always bushy, the wards and O.P.D [Out Patient Department] are congested, and the air is polluted by the community dumpsite close to the hospital.” Toxic chemical, *malodor*, and disease carrying animals *associated with Dumpsite* have been identified as *health hazard agents* (Murti, Ayre, Shapiro, and de Burger, 2011, Oct; Wing, Horton, and Rose, 2013). It is seemingly counterproductive if a patient who has come for healing is exposed to other health hazard-causing agents or is troubled by an offensive odor.

Further on the effect of the physical environment on patients' health, another participant, a pharmacist, said, "Serene environment will speed up healing." The pharmacist suggested, "There should be proper environmental sanitation, the environment should be conducive [to patients] by ensuring the following: adequate power supply, potable water supply, tidy surroundings in terms of keeping the bushes low, and avoidance of any form of pollution." A public health officer added to the above list of facilities; he said, "There is the need to set up a recreational garden on the premises for the use of patients and their family." White affirmed the association between a conducive environment and physical healing. She stated that pure air, sunshine, and a well-groomed environment filled with flowers and trees are health-giving (1990b, pp. 107, 108). As indicated by this discussion on physical environment, care for the physical health is more than the provision of medical treatment and having competent medical personnel. Caring for the physical environment is an integral aspect of physical care and all the above comments suggest that facilities and a tidy environment are essential for patients' comfort and healing.

As pointed out earlier in Chapter 2, diet is closely connected to physical health. The relevance of diet to physical health was also documented in the participants' discussions. A female nurse stated that "providing appropriate diet for the specific ailment of the patients is part of holistic care." The participant's statement is in line with White's statement highlighted in Chapter 2. White stated that good nutrition is for the well-being of physical, spiritual, and mental health, (1954, p. 379). The relevance of appropriate diet to health cannot be overemphasized. It is a common saying that "we are

what we eat.” The worth of good nutrition is even much more acknowledged during illness. Based on my personal experience with illness, poor diet compounds ill health.

Further on patients’ diet, a female doctor noted, “The type of food some family members bring for their sick loved ones sometimes has adverse effects on the patients’ health. The hospital should hire dieticians or nutritionists who can plan their [patients’] diets.” Another participant, a female nurse, also added, “They [the hospital administrators] should hire people who can carry it out at a reasonable cost to patients and more emphasis should be placed on a vegetarian diet.” Participants’ advocacy for a vegetarian diet, dieticians to plan patients’ menu, as well as an appropriate diet confirmed the participants’ desire, as shown by the outcome of the quantitative data, that the feeding of in-patients ought to be the responsibility of BUTH.

There is every indication that BUTH will provide a well-balanced diet for its patients; however, the cost implication, as made reference to above by a participant, is worth paying attention to, more so since patients feel that BUTH present medical charges are high (as will be seen in Chapter 6) compared to other hospitals in the BUTH environs. More often than not, patients who are unable to pay their medical bill are often referred to me for prayer, emotional support, and fundraising; I can imagine the complexity when a meal bill is added to the medical bill. The positive impact of good diet on patients’ physical, spiritual, and mental health, on one hand, and the course implication, on the other hand, needs to be resolved by BUTH.

Summing up patients’ physical care as expressed by the participants, there has to be sufficient and up-to-date medical equipment and sufficient and competent healthcare personnel. The hospital surroundings need to be pleasant and the patients’ diet must be

taken into consideration. Such an approach to physical care is comprehensive; it suggests the need to pay attention to details. Such an approach could serve as a model for the practice of whole patient care.

Participants and Patients' Spiritual Care

Participants noted that BUTH needs to hire full-time chaplains. A female laboratory officer stated, "Let the hospital hire full time female and male chaplains [and] let chaplains take their rightful place." As already noted in the statement of the problem, the participant's suggestion affirmed that BUTH has yet to employ a full-time chaplain. Another participant, a male BU campus chaplain, suggested that "the chaplain (the part-time healthcare chaplain) should intensify efforts to continue to give every patient the type of spiritual care he/she needs and this will go a long way in continuing to boost the social and spiritual morale (life) of patients." These statements seemingly indicate that when approaching spiritual care, the chaplain is the primary provider and this is in line with VandeCreek and Burton, (2001); Handzo and Koenig (2004) postulated that chaplains have received specialized training in spiritual care and although physicians and nurses may have a form of spiritual training, the nature of their job would not allow them to provide comprehensive spiritual care for patients as chaplains would. In addition and perhaps most importantly, the positive impact of spirituality on health documented in Chapter 3 supports the need for full-time trained chaplains at BUTH.

Documented also in the statement of the male BU campus chaplain is the connection between spiritual and social care. He believed that spiritual care will "boost the social and spiritual morale (life) of patients." This insight is apparently true; caring

for the spiritual needs of a patient cannot happen in isolation. The spiritual care provider needs to connect with the patient. It is only as sincere connection occurs that meaningful spiritual care can take place. In addition, as the spiritual care provider connects with the patient, the patient is likely to feel loved and enhanced spiritually. Furthermore and more precisely as pointed out in Chapter 3, every aspect of human life is connected so that none of the parts is thought of as functioning independently of the other parts (Culbertson, 2000).

Furthermore, participants suggested ways to improve spiritual care at BUTH. A male dentist suggested that “airing cool inspirational music via public address devices, conducting daily devotions for patients, having abundant spiritual literature, and good inspirational inscriptions on the wards’ [patients’ rooms] walls (for example, the great physician is here and God loves you), and praying round the clock” will improve spiritual care. The male dentist’s suggestions, though not from the same context, relate to the aspects of spirituality/religion that positively impact spiritual health discussed in Chapter 3. Prayer, peace of mind, and the ability to make meaning of events of life were identified in Chapter 3 as aspects of spirituality/religion that moderate health.

The dentist’s suggestions touched on a vital element—music. Music has been found to help patients cope with illness. In clinical practice, music intervention can be a tool to support emotional, spiritual, and psychological needs by creating an environment that stimulates and maintains relaxation, well-being, and comfort (Nilsson, 2008). To air appropriate music in the OPD and in-patients’ wards is part of the whole patient care proposal on the BUTH administration table. Perhaps the impact of this workshop might facilitate its implementation.

Going further on participants and patients' spiritual care, the idea of physicians and nurses working in alliance with chaplains to provide spiritual care for patients was made reference to by a male physician. He said, "The spiritual [care] should be by all the workers, but especially the chaplain" The statement is observably in harmony with the research findings of Carey and Cohen (2009). As pointed out in Chapter 3, Carey and Cohen acknowledged chaplains as being the primary spiritual care providers; nevertheless, their research findings supported collaboration between physicians [and of course nurses] and chaplains in the provision of spiritual care. Their research findings revealed that collaboration is beneficial to patients and clinical staff. Carey and Cohen stated that chaplains could provide physicians with useful information about patients' spiritual and ethical issues which, in turn, helps physicians care for their patients holistically.

Another benefit that comes to mind is that collaboration between physicians, nurses, and chaplains is likely to help some patients appreciate the need for spiritual care who would not ordinarily see it as an integral part of their medical care. The Director of Clinical Services (John Sotunsa) for BUTH (personal communication, July 19, 2012) said that there is the need for staff (doctors and nurses) to pay attention to the spiritual need of clients and work hand-in-hand with the chaplain and that it is when the staff collaborate with the chaplain that whatever the chaplain is doing can be more effective because clients have tendency to believe doctors and nurses before anyone else. Therefore, he concluded that doctors, nurses, and other healthcare workers need to join the chaplain to promote and provide spiritual care even though the chaplain has the major role to play.

The Clinical Service Director's view that patients have tendency to believe doctors and nurse more may be well-founded. It is a widespread belief among people that when the sick come to the hospital, they are there primarily for somatic-related issues; spiritual care is an added benefit (class lecture, CHMN 788 - Professional Practices in Chaplaincy, February, 2012). Nevertheless, the idea that patients have a tendency to believe doctors and nurses more than chaplains seems to minimize the place of the chaplain on the healthcare team. Rather, I believe that when doctors, nurses, chaplains, and other health caregivers during their individual interaction with a patient offer spiritual care to such a patient, it is likely that such a patient would appreciate better the health benefits of spirituality. For the copious variety of spiritual benefits to patient's health, it is important for doctors, nurses, chaplains, and other healthcare professionals on the patients' care team to collaborate.

Participants and Patients' Social Care

Participants discussed that the lack of a social worker job description affects whole patient care at BUTH. A matron (senior nurse) said, "Let the social worker work as a social worker and not as a public health officer." Based on the matron's explanation, the social worker also serves as the public health officer and tends to focus more on public health assignments than on social work.

A limited direct discussion on the role of the social worker during the FGD became obvious to me. Nevertheless, it appears that participants understood the importance of the social relationship and its impact on health. A female nurse said, "There should be a good relationship between staff and patients; there should be a one-on-one interaction with patients—know about their emotional and other needs." Another

female nurse stressed, “Staff should treat all patients with respect irrespective of sex, gender, class, and age; promotion of whole patient care should start from the first day of the patient’s care right at the reception.”

The fact that “social work” and “social workers” nomenclature was only used in a very limited manner (as an item on a list) in the FGD narrative does not mean that the issues related to social work were ignored. In fact, when talking about gender, age, social standing, and economic access of families and patients, the very issues dealt with by social workers were acknowledged as integral to whole patient care. The impetus was to reshape the social worker’s role away from public health and into social concerns.

Furthermore, a public health officer stated, “Family is important because they take care of the patients. If a family is treated rudely, the patient will not be happy and that may affect the health of the patient.” This suggests that the cordial rapport suggested between staff and patients ought to be extended to the patients’ family. Relationship is central to social care and as defined earlier; social care is about the positive association as provided and experienced by the individual in the context of support and coping with illness (Wright, 2008). Thus, the participants’ statements highlighted above, as well as the outcome of the quantitative data suggest that participants understood the role of the social worker and the place of social care in whole patient care.

Participants and Patients’ Emotional Care

The analysis of the qualitative data revealed that participants had limited discussion on the emotional care of patients during the FGD. The likely reason for this will be discussed shortly and in Chapter 6. Nevertheless, a female doctor stated that “the emotional aspect should be taken care of by the nurses, doctors and chaplain.” This

seemingly suggests that participants saw the need to care for patients' emotions. In support of this conclusion is the outcome of the quantitative data. Documented here, also, is the participant's recognition of collaboration among healthcare team in meeting patients' emotional needs.

Concluding Statement

It is my conclusion that the results of this study indicate that the workshop had a positive influence on participants' awareness of and attitude to whole patient care. Participants saw the connection between the physical, spiritual, social, and emotional aspects of human life and saw the need to care for each of these aspects when illness presents. The result of the study also indicated that participants wished for full-time chaplains and social workers and collaboration among health caregivers in providing wholistic care.

Having said that, the analysis of the qualitative data revealed that participants dwelt more on three areas of whole patient care while ignoring one. The physical, spiritual, and social aspects were discussed at length while the emotional was apparently ignored. Of all four, physical care received the most coverage and attention. The explanation could be (a) that the open-ended questions did not clearly state that each question should be addressed in the light of the physical, social, spiritual and emotional aspects. Future research needs to take note of that when adopting the FGD as a qualitative research method. Nevertheless, allowing participants to discuss "freely" revealed that although participants saw the importance of whole patient care and wished for it, the physical aspect overtook in importance in the dialogue while the emotional aspect was ignored. (b) Could it be that Nigerian cultural mores (as interpreted and experienced by

BUTH healthcare workers) are similar, namely, that expressing emotions in a public or an educational context is less than desirable ? This idea and others will be explored further in the next chapter.

CHAPTER 6

BUTH PHILOSOPHY AND DEFINITION OF WHOLE PATIENT CARE, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter explores BUTH philosophy and definition of whole patient care. The exploration is vital to the development, success, and sustainability of whole patient care at BUTH. This chapter also summarizes the study, draws conclusion, and makes recommendation.

BUTH Philosophy of Whole Patient Care

BUTH is a developing healthcare institution that is seeking ways to develop whole patient care. One of the tasks of this study, as stated in Chapter 1, is to develop BUTH philosophy and definition of whole patient care, based on the participants' responses to survey and focus group discussion (FGD) questions. The results indicated that BUTH staff members' awareness of and attitude to whole patient care was deepened through their participation in the whole patient care workshop. While participants embraced caring for the physical, spiritual, social, and emotional aspects of patients as discussed in Chapter 5, they were of the opinion that whole patient care needs to take into consideration certain factors for it to be successful and sustained at BUTH.

Emerging from these factors is the BUTH philosophy and definition of whole

patient care. Participants identified a reduction in patients' medical bill, staff welfare package and motivation, leadership attitudes, and development of policy as factors vital to whole patient care development and sustainability at BUTH. Details of each of these factors are hereby presented.

Reduction in Medical Bill

The participants identified high medical bills as one of the factors influencing whole-patient care at BUTH. A maintenance officer said, "Community patients complain about high prices and even Babcock staff do complain." Due to the complaint about the high price, participants assumed that patients may reject whole patient care: "When we want to show that we are concerned about their total well-being they may not take us serious because of the high price," said a female nurse. Reduction in patients' medical bill was considered by participants as one of the ways to improve whole patient care at BUTH. A male doctor pointed out that patients' medical bills should be reasonable; he said, "Reduce hospital bill, review and compare BUTH medical bill to other hospitals' bills—and that which is currently charged needs to be reviewed." The doctor added "We need to put ourselves in the shoes of those patients; our whole patient care needs to be total."

On the premise of the above statements, one can conclude that BUTH believes that in the provision of whole patient care, patients ought to be treated as one would like oneself to be treated. This suggests that staff ought to put themselves in the shoes of patients on any patient issue. This idea is biblical; it is called the golden rule—"Do to others as you would have them do to you" (Luke 6:31, NIV). Furthermore, the idea is portrayed in the earthly ministry of Jesus Christ. As seen in Chapter 2 of this research,

Jesus is touched by human infirmities (Hebrews 4:11).

It should be noted that the complexity of healthcare workers' earned salary, income received from patients' hospital bills, and balancing a hospital budget was part of the dialogue when the whole group came together at the end of both days of workshop. However, such dialogue was not included in the FGD, thus it is ignored here.

The FGD dialogue had a unilateral focus on philosophical perspectives provided by Christianity and Adventist believes. Putting oneself in the patients' shoes is the foundation for compassion and it seems that whole patient care should be driven by compassion. As expressed by the FGD at BUTH, whole patient care involves whole patient care providers putting themselves in the shoes of patients by somehow, perhaps miraculously, devising a formula for reducing cost.

Staff Welfare Package and Motivation

Participants concluded that in order to motivate staff for increased whole patient care, the employee welfare package ought to be enhanced. A female nurse stated, "Staff promotion is irregular; people have worked for 15 years without being promoted. Improvement in staff welfare, proper remuneration of staff, rewarding best performance among workers, and motivation such as words of encouragement, appreciation, and a crèche for staff babies would enhance staff efficiency; absences may affect the caregivers and the patients." The definition provided here for "welfare" is a complex one with monetary and promotional aspects, as well as emotional and philosophical overtones. As discussed below, Lindner and Smith agree with BUTH staff.

Participants felt that the health caregivers' welfare is germane to optimal performance in the delivery of whole patient care. Thus, demanding improved staff

welfare package, and adequate motivation in order to carry out whole patient care effectively can be seen in the light of a staff need for motivation. According to Lindner (1998), citing Smith (1994), a motivated employee is the answer to organizational survival and productivity. Lindner examined the ranked importance of motivational factors of employees at Ohio State University's Piketon Research and Extension Center and Enterprise Center. The result of his study indicated that interesting work and good pay ranked highest among the ten motivating variables examined. Lindner concluded that to motivate employees for optimal performance, consideration needs to be given to the following motivating factors: job enlargement, job enrichment (making job interesting), promotions, internal and external stipends, monetary, and non-monetary compensation. Lindner's finding supports the BUTH philosophy that health caregivers' welfare is important in achieving optimal performance in the delivery of whole patient care. Thus, the literature list of job enhancement elements and the FGD are in concert.

As stated in Chapter 1 of this document, Seventh-day Adventists and biblical teachings value whole patient care; both sources are fully embraced at BUTH. On one hand, note Jesus' statements that follow: "Don't hesitate to accept hospitality, because those who work deserve their pay" (Luke 10:7 NLT) and "Well-done, good and faithful servant! You have been faithful with a few things. I will put you in charge of many things. Come and share your master's happiness" (Matthew 25:21 NIV. Note also White's statement:

Remember that the workers should be paid according to their faithfulness. . . . It would be far better to expend less in buildings and give your workers wages that are in accordance with the value of their work, exercising toward them mercy and justice. (1948c, p. 143)

This suggests that workers' welfare, especially wages, is not negotiable. When people

work, they must be paid based on whatever terms were agreed upon. On the other hand, White said,

[The suggestion that] if we paid higher wages, we could secure men of ability to fill important positions of trust. This might be so, but I should very much regret to see our workers held to our work by the wages they receive. There are needed in the cause of God workers who will make a covenant with Him by sacrifice, who will labor for the love of souls, not for the wages they receive. (1923, p. 302)

This suggests that workers should not tie their performance to wages. BUTH staff needs to continue to deliberate on the motivational aspect of the philosophy as they work to establish whole patient care at BUTH. Nonetheless, it needs to be understood that these statements do not suggest that organizational management should not motivate workers.

White wrote,

Every worker in our institutions should receive fair compensation. If the workers receive suitable wages, they have gratification of making donations to the cause. It is not right that some should receive a larger amount, and others, who are doing essential and faithful work very little. (1951, p. 305)

Leadership's Attitude and Development of Policy

The participants felt that the success of whole patient care depends on leadership's attitude and skill. Adequate supervision and development of BUTH policy for whole patient care by the leaders were considered a great asset for sustaining whole patient care. A nurse female employee suggested, "Administrators should enroll in leadership training; leadership must ensure that staff carry out whole patient care, staff must be mandated to give a report of care provided to patients, [and] there must be proper implementation of FGD suggestions."

Based on the above statements, one can conclude that at BUTH, the leadership attitude is a determinant factor for whole patient care success and sustainability. This idea

is not in isolation. In McNeese-Smith's words, "leadership behaviors are directly relate to employees satisfaction productivity and organizational commitment" (1992, p. 396).

Similarly, Appelbaum, St-Pierre, and Glavas (1998) pointed out that success and failure of an organization could be management oriented; this means that the rise and fall of an organization is associated with leadership style. Furthermore, White , writing concerning church leaders' approach, stated that harshness, severity, and a domineering spirit cause a lot of harm to church members and church workers (1995, p. 53).

Mack (n. d.) stated that when a leader understands leadership theories, he or she would develop a leadership behavior that positively affects workers' performance. Recounting Moses' retraining in the wilderness for the task ahead of him, White supported the need for leaders to be trained in leadership skill (1995, p. 53). Mack and White's statements affirm the participants' suggestion that BUTH administration needs to enroll in leadership training. The BUTH philosophy on leadership attitude as a determinant factor for whole patient care success and sustainability is founded.

BUTH Definition of Whole Patient Care

The BUTH definition of whole patient care emphasized quality physical, spiritual, social, and emotional care of patients. This could be deduced from many of the participants' statements. For example, participants recommended a yearly evaluation of whole patient care practice at BUTH. A female doctor stated, "At the end of the year, write your report; submit your report of your practice of whole patient care." Also, participants also challenged BUTH leadership concerning proper implementation of whole patient care principles as presented during the workshop. A female laboratory worker stated, "There must be proper implementation of all necessary suggestions made

by the groups and all that this workshop has taught.” Further, participants frowned at medical treatment that is based on trial and error. A male nurse stated, “Staff should handle patients’ cases in which they have expertise and are naturally and intellectually endowed.” All these statements have in common the need for listening and responding within the BUTH family of employees. A desire for quality and open communication is also implied.

The BUTH definition also embraced collaboration among the health team and chaplains and social workers on the care team. The BUTH definition of whole patient care does not seem to emphasize giving care with the whole person of the caregiver; rather, BUTH looked at staff welfare and motivation as key to providing quality whole patient care. This does not suggest that BUTH rejects the importance of giving care with the whole person of the caregiver; it could be that participants felt that giving care with the whole person of the caregiver is more feasible when the welfare of the care provider is met.

Summary

The need to develop whole patient care at BUTH gave birth to this research. This study investigated BUTH health caregivers’ awareness of and attitude towards whole patient care. The SDA church places a high value on whole person care and the association between physical, spiritual, social, and emotional aspects of human life.

The purpose of the study was to develop whole patient care at BUTH. To achieve this purpose, a two-day workshop was organized. The workshop was in two segments. The first segment focused on the connection that exists between every aspect of human life—spirituality, emotional, social, and physical; the positive impacts of spirituality,

emotion, and social aspects of human life on health; and the biblical model of Jesus Christ's ministry and Ellen G. White's teachings on wholeness. The second segment was a Focus Group Discussion (FGD) conducted to determine how to contextualize whole patient care in the BUTH setting. Literature pertinent to the study was reviewed and the study also explored the biblical foundation of whole patient care.

This study employed a quantitative (survey) and qualitative (FGD) mixed methods research design. Sixty-six (66) participants took part in the study. Fifty-four (54) of the 66 completed the questionnaire for quantitative survey, while all the participants took part in the FGD.

The analysis of the quantitative data indicated that the overall mean score after the workshop was higher than the mean score before the workshop ($p < 0.05$). Emerging from the analysis of the FGD was the BUTH philosophy and definition of whole patient care which focused on the connection between quality whole patient care, caregivers' welfare/motivation, and attitude of leadership. Overall analysis of both the quantitative and qualitative data indicated that the workshop had a positive impact on the participants' awareness of and attitude to whole patient care.

This study has broadened my research skills in the area of whole patient care. Using a mixed method research design helped me to gain insight into the BUTH staff world view on whole patient care which will help me as I continue to help develop and evaluate whole patient care at BUTH.

Conclusions

Whole patient care takes into account the physical, spiritual, social, and emotional aspects of patients when illness presents. The reason for this is that all of the aspects are

woven together. Abundant research documented the connection between physical, spiritual, social, emotional aspects of human life and the impacts of spiritual, social, emotional aspects of human life on health. The human is a whole. As stated by Meyerstein (2005), illness affects the physical, emotional, social, and spiritual aspects of the human and thus, when ill health is addressed, other aspects of the human must also be addressed.

Wholistic care is fundamental to the Seventh-day Adventist Church; it is Bible-based. As presented in Chapter 2 of this research, the earthly ministry of Jesus Christ typified whole patient care—He healed the physical body and spiritual decay; He took cognizance of and addressed people's emotional and social needs. Ellen G. White, a prophetess in the SDA Church, affirmed the need for whole patient care.

Crucial to caring for the whole patient is the person of a caregiver. As exemplified by Jesus' examples cited in Chapter 2, a caregiver ought to care with every aspect of his or her life; thus, in this research, whole patient care is defined as care for the whole person of the patient and also giving care with the whole person of the caregiver; each involves the complete human: physical, spiritual, emotional, and social aspects that define the human condition (Rice, 2004).

Whole patient care providers are also vital to whole patient care. Based on the literature reviewed, while chaplains and social workers are adjudged spiritual and social care providers respectively, emphasis is laid on the need for every caregiver on the patient care team to collaborate in providing wholistic care.

Based on the importance of whole patient care, this study explored the awareness of and attitude to whole patient care among BUTH caregivers for the purpose of

developing whole patient care at BUTH. The result of this study indicated a positive increase in the participants' awareness of and attitude to whole patient care. Participants acknowledged the connection between the physical, spiritual, social, and emotional aspects of human life and the need to care for each of these aspects when illness presents. The result of the study also documented that participants valued collaboration among health caregivers in providing wholistic care and, at the same time, recognized the specific role of healthcare chaplains and healthcare social workers.

Furthermore, the FGD experiences highlighted the apparent BUTH silence on the discussion of emotions—emotions were barely discussed when thinking of whole patient care. It is unclear whether the participants, as Nigerians (100% of participant employees were Nigerian), were bound by a philosophy that expressing emotions in public or in an educational/formal setting is less than desirable. There seemed to be no published articles to support such an assertion about Nigerian cultural mores. Therefore, there is a need for the apparent BUTH silence on the discussion of emotions during FGD to be explored, perhaps in a follow-up to this study. Nevertheless, emotional expression in whole patient care is vital. As learned by Balogun and Olowodunoye (2012), for a segment of Nigerian professional employees (they surveyed 215 bank employees), emotions cannot be ignored when thinking of employees' well-being, job satisfaction, and turn over intentions. Thus, I suggest that in promoting whole patient care, BUTH Administration ought to consider training caregivers on emotional expression and legitimacy of emotions, as the caregivers help their patients and their families, as well as relate with other healthcare workers.

While participants supported and wished for development of whole patient care,

its success and sustainability at BUTH depends largely on leadership attitude and staff welfare and motivation, as indicated by the participants. Apparently, and even more important to me, the workshops facilitated a change in the opinion of many of the participants who at the beginning thought BUTH had no further need for change in their philosophy of care and approach; the new perceived need for an improved whole patient care was indicated in the post-workshop survey.

Recommendations

Whole patient care is vital to patient health outcome. Therefore:

1. In the light of the findings of this research, there is a critical need for the implementation and allocation of resources for the establishment of a Chaplaincy Program at BUTH including a chaplain, a strategy for whole patient care promotion, and the training for whole patient care.
2. Management and human resource personnel at BUTH ought to design intervention strategies for facilitating communication and management of emotions to promote employees whole person care as well as whole patient care. A dialogue between BUTH management and staff on staff welfare/motivation and its influence will facilitate quality whole patient care, as well as facilitate the promotion of overt and positive management of emotions.
3. The implementation of a whole patient care philosophy and methods at BUTH will require a master plan and continual evaluation of BUTH staff performance in relation to this current training on whole patient care.
4. As revealed by the literature reviewed, Nigeria is still significantly behind in empirical studies on whole patient care. There is the need for more studies on whole

patient care in Nigeria for the purpose of spreading the practice in Nigeria's healthcare institutions, particularly SDA healthcare institutions.

5. BUTH management is encouraged to continue in the path they began when they approved the participation of the whole employee and staff in the whole patient care workshops. Now is the time to continue this effort to assure the fulfillment of the BUTH vision as a Seventh-day Adventist institution seeking to serve its community and the world with the highest standards of care.

APPENDIX A

PARTICIPANT INVITATION LETTER

Andrews University
Seventh-day Adventist Theological Seminary

Participant Invitation Letter

Babcock University Medical Center
Ilisan-Remo, Ogun state Nigeria

May 1, 2011

Dear _____

You have been selected to participate in a study on whole patient care at Babcock University Medical Center. Your selection is based on your experience and the key role you play in patient care at your hospital.

The study is a part of a research project required for the completion of a Doctor of Ministry degree in Health Care Chaplaincy at Andrews University Seventh-day Adventist Theological Seminary, Berrien Spring Michigan. Alongside with me are two other experts in the field of health care chaplaincy to run the workshop. To ensure your privacy (confidentiality), the two experts will sign a confidentiality agreement and comply with Andrews University Standards for the Protection of Human Research Participants. I am hopeful that the study will enhance whole patient care in your hospital. The final research report will be share with you as one of the research participant. The outcome of the workshop will be made available to the BU administration and BUMC medical director for further discussions for the purpose of implementation. The outcome of the workshops could also serve as a template for other SDA hospitals in Nigeria. I am required to let you know that your participation in the study is voluntary and that you have the right to opt out of the study at any time without prejudice from the researcher or your organization.

The plan for this study has been reviewed and approved by Andrews University Office of Scholarly Research Berrien Springs, Michigan 49104-0355. For Question regarding the rights of research subjects, you may contact the office through Telephone or e-mail (269) 471-6361, email: irb@andrews.edu, respectively. For other questions or complaints you may have about the study please ask Victoria Aja in person or call her at 08068238469. You may also contact her supervisor Johnny Ramirez-Johnson at jramirez@llu.edu.

Best wishes

Victoria T. Aja
Chaplain Babcock University

APPENDIX B

PARTICIPANT CONSENT FORM

Andrews University
Seventh-day Adventist Theological Seminary

WHOLE PATIENT CARE: AWARENESS AND ATTITUDE OF HEALTH CAREGIVERS IN BABCOCK UNIVERSITY MEDICAL CENTER

PURPOSE AND PROCEDURES:

You are invited to participate in a study as part of a student project. The study seeks to understand BUMC health caregivers (nurses, doctors, and other patient care personnel) level of awareness and attitude towards whole patient care and find ways to improve whole patient care at BUMC. Your participation in the study will take two days. Being a two day workshop, light refreshment and one meal will be provided for participants on both days.

RISKS:

Your participation in this study post minimal to no foreseen risk to you. Possible sensitivity with the patient care topic in the Babcock University Medical Center environment may produce some discomfort and/or emotional distress, though remember, you will express whatever you wish, no compulsory means will be used that could prevent and/or force you to express any and all ideas about the topics discussed in the workshops.

BENEFITS:

There are no direct benefits to you; however, your participation in the study will provide you and your hospital with information on whole patient care and its impacts on patients' health. It is expected that the outcome of the study will enhance whole patient care at your hospital and that the outcome will also serve as a template for other Seventh-day Adventist Hospital in Nigeria. This workshop will also serve as continual education for you since you will have a chance to learn about whole person care.

PARTICIPANTS' RIGHTS:

Participation in this study is voluntary. Your decision whether or not to participate will not prejudice your future relationships with your hospital, or the researcher. You are free to withdraw your consent and to discontinue participation at any time without penalty.

Initial _____

Date _____

CONFIDENTIALITY: To ensure your privacy (confidentiality) you are asked not to write your name on the questionnaires and proceedings from the group session. Any information obtained from your participation will not be identified by name but by a number that will be assigned to you by the principal investigator. You will use the assigned number on the questionnaires and proceedings from the group session.

CONTACTS: For questions or complaints you may have about the study please ask Mrs. Victoria Aja, MA, DMin (student) in person or call her at 08068238469. You may also contact her supervisor Prof. Johnny Ramirez-Johnson at jramirez@llu.edu. Question regarding the rights of research subjects may be directed to Andrews University Office of Scholarly Research Berrien Springs, MI 49104-0355. Tel. (269) 471-6361, email: irb@andrews.edu

INFORMED CONSENT STATEMENT: HAVING listened to and satisfied by the verbal explanation given by the investigator concerning the study and having READ THE INFORMATION PROVIDED ABOVE and having been given a copy of this consent form, I hereby give my voluntary consent to participate in the study.

Signature of the subject

Date

I have reviewed this consent form with the person signing above. I have explained potential risks and benefits of the study.

Investigator's signature

Date

APPENDIX C

PROGRAM OF EVENTS

Andrews University Seventh-day Adventist Theological Seminary

Day one: Lectures and Discussion

Timeline

09:00 AM - 10:00 AM	Opening Ceremony: Vice Chancellor, Babcock University
09:30 AM - 10:30 AM	Lecture Part: Disseminate information on the connection that exists between spirituality, emotion, social, and physical aspects of human life.
10:30 AM - 11:30 AM	Discussion Part: Disseminate information on the connection that exists between spirituality, emotion, social, and physical aspects of human life.
11:30 AM - 12:30 PM	Lecture Part: Disseminate information about the positive effects of spirituality, emotion, and social, aspects of human life on health.
12:30 PM - 1:30 PM	Discussion Part: Disseminate information about the positive effects of spirituality, emotion, and social, aspects of human life on health.
1:30 PM - 2:30 PM	Lunch Break (provided)
2:30 PM - 3:30 PM	Lecture Part: Disseminate information about Jesus method's of healing ministry and Ellen G. White's perspective on whole patient care.
3:30 PM - 4:30 PM	Discussion Part: Disseminate information about Jesus method's of healing ministry and Ellen G. White's perspective on whole patient care.

Day two: Focus Group (Divide participants into groups)

09:00 AM - 09:20 AM	Devotional
09:30 AM - 10:30 AM	Find out factors influencing whole patient care at BUMC
10:30 AM-11:30 AM	Develop strategies on ways to improve whole patient care at BUMC.
11:30 AM - 12:30 PM	Develop an on-going strategy for regular training.
12:30 PM - 2:00 PM	Presentation of report
2:30 PM - 4:00 PM	Question and answer
4:00 PM - 4:30 PM	Completing the survey and closing activities

Resource Personnel for the workshop:

Mrs. Victoria Aja M.ed, MA (principal investigator)
Prof. Johnny Ramirez-Johnson E.dD, MA (presenter)
Dr. John Sotunsa MD (presenter)

APPENDIX D

QUESTIONNAIRE ON AWARENESS AND ATTITUDE OF WHOLE PATIENT CARE FOR DOCTORS, NURSES, AND HOSPITAL PATIENT CARE PERSONNEL

Andrews University
Seventh-day Adventist Theological Seminary

QUESTIONNAIRE ON AWARENESS AND ATTITUDE OF WHOLE PATIENT CARE FOR DOCTORS, NURSES, AND HOSPITAL PATIENT CARE PERSONNEL

INSTRUCTIONS:

Please read the following statements and circle your level of agreement with each one individually, from Strongly Disagree, Disagree, Agree, to Strongly Agree. Please circle your selected answer.

Section A: Socio-demographic data

Age: ----- Sex: Female / Male
Marital Status: Single / Married / Widow / Widower/ Divorced / Other (specify) -----
Religious Affiliation: SDA ----- Non SDA (specify) -----
Member Affiliation: Doctor / Nurse / Others (hospital patient care personnel specify) -----
Highest Educational Level: RN / Midwifery / Bsc. / Msc / Bachelors in Medicine / Other (specify) -----

Section B: Survey Items:

1. The level of spiritual and religious involvement of patients positively affects their health care outcomes.	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
2. A Chaplain plays a key role in a health care system.	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
3. The services of chaplain at BUMC would enhance patients' health outcome	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
4. Chaplaincy services will be highly valued by BUMC staff and patient	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
5. Spiritual beliefs can be beneficial to coping with illness	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
6. Spiritual care is an integral part of whole patient care	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
7. Health caregivers should consider inquiring about patients' Spirituality	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
8. Health caregivers should pray with their patients	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4

9. The role of a nurse/doctor is to treat disease, the spiritual aspect is not part of their job description	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
10. There is a positive connection between social support and health outcome	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
11. Patients feel comfortable and open up to health caregivers who genuinely identify with them and who took interests in them as a person	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
12. Asking patient about their social supports is overstepping professional boundary in health care system	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
13. Social workers can help preserve person-centered value in hospital settings	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
14. A hospital Social worker has positive role to play in whole patient care	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
15. Having a social worker as team member of health caregiver is unnecessary	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
16. Emotions have implication for quality of life	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
17. Emotions have implication for patients' health outcome	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
18. Patients emotions are private to them	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
19. Doctors/nurses should seldom explore patients' deep feelings	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
20. Poor nutrition affects patients' health outcomes	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
21. The meals served to BUMC patients do meet the best nutritional principles	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
22. The feeding of patients should be the sole responsibility of the BUMC	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
23. Patients value efficient and qualified health caregivers	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
24. Ill health negatively affects quality of individuals' life	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
25. BUMC has enough health caregivers to care for all of its patients	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
26. BUMC has enough facilities to care for all of its patients	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4
27. BUMC has sufficiently qualified health care givers to care for all of its patients	Strongly Disagree-1 Disagree-2 Agree-3 Strongly Agree-4

APPENDIX E

WORKSHOP OPENING CEREMONY GROUP PHOTO



APPENDIX F

INSTITUTIONAL REVIEW BOARD APPROVAL



Institutional Review Board

Tel: (269) 471-6361 Fax: (269) 471-6246 E-mail: irb@andrews.edu
Andrews University, Berrien Springs, MI 49104-0355

April 12, 2011

Victoria Tayo Aja
Babcock University
Tel: +2348068238469
Email: ajavictayo@yahoo.com

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS

IRB Protocol #: 11-059 **Application Type:** Original **Dept.:** Doctor of Ministry
Review Category: Exempt **Action Taken:** Approved **Advisor:** Johnny
Ramirez-Johnson

Title: Whole patient care: awareness and attitude of health caregivers in Babcock
University Medical Center

This letter is to advise you that the Institutional Review Board (IRB) has reviewed and approved your proposal for research entitled: "Whole patient care: awareness and attitude of health caregivers in Babcock University Medical Center" IRB protocol number 11-059 under Exempt 46.101 (b) (2). We ask that you reference the protocol number in future correspondences regarding this study. This approval is valid until March 16, 2012. If your research is not completed by the end of this period you must apply for an extension at least two weeks prior to the expiration date. We also ask that you inform IRB whenever you complete your research. Any future changes made to the study design and/or consent form require prior approval from the IRB before such changes can be implemented.

While there appears to be no risks with your study, should an incidence occur that results in a research-related adverse reaction and/or physical injury, this must be reported immediately in writing to the IRB. Any project-related physical injury must also be reported immediately to the University physician, Dr. Loren Hamel, by calling (269) 473-2222.

We wish you success in your research project as outlined in the approved protocol.
Please feel free to contact our office if you have questions.

Sincerely

A handwritten signature in cursive script, appearing to read "Sarah Kimakwa".

Sarah Kimakwa
IRB, Research & Creative Scholarship
Tel: 269-471-6361
Fax: 269-471-6246
IRB email: irb@andrews.edu
Research email: research@andrews.edu

APPENDIX F (CONTD)

INSTITUTIONAL REVIEW BOARD EXTENSION PERMISSION

Victoria,

Ok good to know that. Based on this information then your extension granted. Since your study is Exempt unless you change the informed consent form or research protocol you are not required to seek for future extension.

Best wishes in your research and studies.

Sarah Kimakwa

IRB, Research and Creative Scholarship

Tel: (269) 471-6361

Fax: (269) 471-6543

Email: irb@andrews.edu

research@andrews.edu

From: VICTORIA AJA [mailto:ajavictayo@yahoo.com]

Sent: Wednesday, April 11, 2012 1:20 PM

To: IRB

Subject: RE: IRB Extension

Dear Sarah,

Greetings and thanks for your prompt response.

My research protocol and or informed consent and nothing else have changed since the study was approved.

Sincerely,

Victoria Aja

APPENDIX G

BABCOCK UNIVERSITY ETHICAL COMMITTEE APPROVAL



**BABCOCK UNIVERSITY
MEDICAL CENTRE**

15/03/2011

Victoria Tayo Aja,
Babcock University,
Chaplaincy Unit,
Ilishan-Remo,
Ogun State.

Dear Ma,

RESEARCH STUDY

Following your request to carry out a research study at our centre on Health Care Givers' Level of Awareness and Attitude Towards Whole Patient Care and Ways to Improve it. The Ethical Committee of Babcock University Medical Centre hereby approve your request to commence the study from June 2011.

Thanks:

Mrs. Ladipo Kemi
Secretary-Ethical Committee

Ilishan-Remo, Ogun State, P.M.B. 21244, Ikeja, Lagos, Nigeria. Tel: 0803 600 9740, 0803 9788 026, E-mail: bume@babcockuni.edu.ng, www.babcockuni.edu.ng

APPENDIX H

ANALYSIS OF THE WORKSHOP EVALUATION SURVEY

Simple percentage method was adopted to analyze the workshop evaluation questions (the evaluations are stated on page--). Fifty four participants filled the workshop evaluation questionnaire on awareness and attitude of whole patient care for doctors, nurses, and hospital patient care personnel.

Table 1

The Workshop Addressed Its Main Objective

Response		Strongly Disagree	Disagree	Agree	Strongly Agree	Total	MS
Response Value		(1)	(2)	(3)	(4)		
N	54						
Frequencies		4	1	11	37	53	1
Percent		7.41%	1.85%	20.37%	68.52%	98.15%	1.85%
Valid Percent		7.55%	1.89%	20.75%	69.81%	100%	
Mean	3.46	The mode for question one was 4 (68.52%) which showed that the majority of the participants strongly agreed that the workshop addressed its main objectives.					
Median	4						
Mode	4						

Note. N = Number of participants that responded to the evaluation questionnaire
MS = Missing Data

Table 2

The Workshop is Timely in the History of Babcock University Medical Center

Response	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	MS
Response Value	(1)	(2)	(3)	(4)		
N	54					
Frequencies	1	4	22	26	53	1
Percent	1.85%	7.41%	40.74%	48.15%	98.15%	1.85%
Valid Percent	1.89%	7.55%	41.51%	49.05%		
Mean	3.38	<p>The mode for question 2 was 4. This showed that majority (49.05%) of the participants strongly agreed that the workshop was timely in the history of Babcock University Medical Center</p>				
Median	3					
Mode	4					

Table 3

The Workshop has Positive Impact on My Person

Response	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	MS
Response Value	(1)	(2)	(3)	(4)		
N	54					
Frequencies	1	0	18	32	51	3
Percent	1.85%	0.00%	33.33%	59.26%	94.44%	5.56%
Valid Percent	1.96%	0.00%	35.29%	62.75%		
Mean	3.59	<p>The mode for question 3 is 4 which shows that majority (62.75%) of the participants strongly agreed that the workshop had positive impact on their person</p>				
Median	4					
Mode	4					

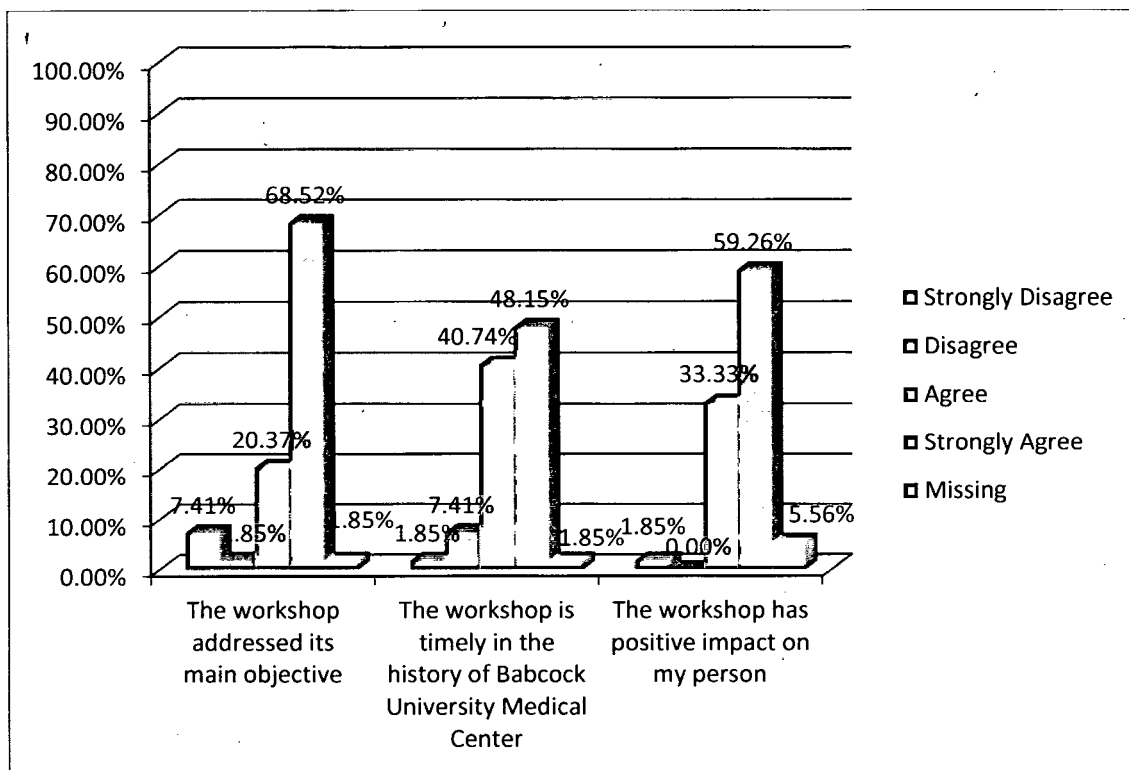


Figure 1. Percentages of response to evaluation item 1 - 3

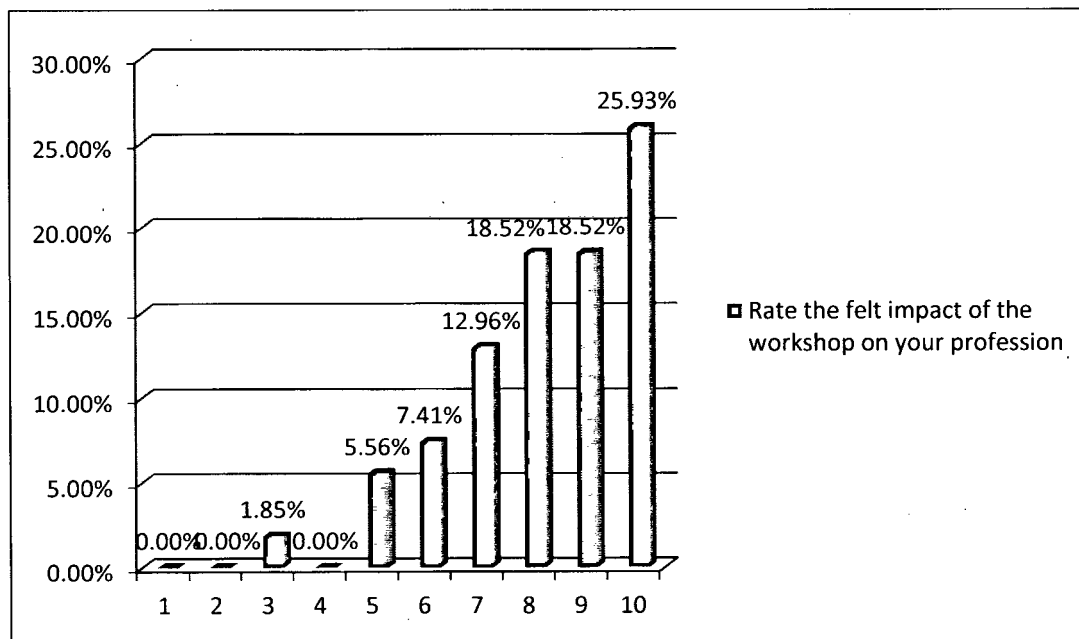


Figure 2. Percentages of response to evaluation item or question 4

Table 4

The Workshop has Positive Impact on My Profession

		A scale of 1 – 10 (10 being the greatest value)										Total	MS
Response Value		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)		
N	54												
Frequencies		0	0	1	0	3	4	7	10	10	14	49	5
Percent		0.00%	0.00%	1.85%	0.00%	5.56%	7.41%	12.96%	18.52%	18.52%	25.93%	90.74%	9.26%
Valid Percent		0.00%	0.00%	2.04%	0.00%	6.12%	8.16%	14.29%	20.41%	20.41%	28.57%		
Mean	8.14	The mode for item 4 was 10 which indicates that majority of the participants, 28.57% agreed that the workshop positively affected their profession											
Median	8												
Mode	10												

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VITAE

Personal Data:

Name: Victoria Tayo Aja
Date of birth: October 24, 1965
Marital status: Married
Current address: Babcock University Division of Spiritual Life
Ilishan-Remo Ogun State Nigeria
Telephone: 0112348068238469
E-mail: ajavictayo@yahoo.com

Detail of Work Experience:

Assistant Chaplain, Ile-Ife Seventh-day Adventist Hospital Ile-Ife (March 1991 – Nov. 1991)
Instructor, Voice of Prophecy, West Nigeria Conference of SDAs (1991 – March 1994)
Administrative Officer, Registry, Adventist Seminary of West Africa (1994 – 1995)
Administrative Officer, Academic Dean's Office, Adventist Seminary of West Africa (1995 – 1998)
Senior Administrative Officer, Deputy Vice Chancellor's Office, Babcock University (2001 – 2002)
Deputy Director for Chaplain Services, Babcock University (2002 – 2004)
Graduate Assistant, Loma Linda University School of Religion (2005-2007)
Chaplain, Babcock University (2008-to-date)

Dissertation and Thesis:

M.Ed: School-community relations among public secondary schools in Ikenne Local Government Areas, Ogun State, Nigeria
M.A: A Study of the role of Spirituality and meaning in the Lives of Individuals with Severe Depression (a publishable paper)
On-going Doctor of Ministry (Approved Title): *Whole Patient Care: Awareness and Attitude of health caregivers in Babcock University Medical Center*

Publications:

Aja, V. T. (1999). *ABC of the Bible*. Lagos: Health Action Publishers.

Sorajjakool, S., Aja, V., Chilson, B., Ramírez-Johnson, J., & Earll, A. (2008, March). Disconnection, depression, and spirituality: A study of the role of spirituality and meaning in the lives of individuals with severe depression. *Journal of Pastoral Psychology*, 56, 521-532 doi 10.1007/s11089-008-0125-2.